This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Falure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 151319	Period: From 10/01/2011 To 09/30/2012	Worksheet S Parts I-III Date/Time Prepared: 2/20/2013 2:45 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/20/2013 Time: 2:45 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GIBSON GENERAL HOSPITAL (151319) for the cost reporting period beginning 10/01/2011 and ending 09/30/2012 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 2/20/2013 Time: 2:45 pm
dq4C.tPWlw1HJjoPEuO.5CnT95j3LO
nmYi8OGtQF2LSyainrlOQCVsCJ2mv1
TqML03EuQSOQZa14
PI: Date: 2/20/2013 Time: 2:45 pm
o6Wzh2WWt7KtB.lM:QOgHVW02hKHwO
CpIC2OvvuoP1CXUiurQTHPkONksPGf
EbwdVMOHsXO.eImw

(Signed) Ron Hamilton
Officer or Administrator of Provider(s)

VP + CFO
Title

2-25-2013
Date

PART III - SETTLEMENT SUMMARY

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital	0	68,974	-302,747	0	1,397,772	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I	0	0	0		0	4.00
5.00	Swing bed - SNF	0	33,019	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	1		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	101,993	-302,746	0	1,397,772	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet S-2 Part I Date/Time Prepared: 2/20/2013 1:52 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1800 SHERMAN DRIVE	PO Box:			1.00
2.00	City: PRINCETON	State: IN	Zip Code: 47670-	County: GIBSON	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	GIBSON GENERAL HOSPITAL	151319	21780	1	12/16/2003	N	O	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	GIBSON GENERAL SWING BED	15Z319	21780		12/16/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	GIBSON GENERAL SNF	155093	21780		06/14/1969	N	P	O	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	GIBSON HOME HEALTH	157445	21780		10/19/1995	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2011	09/30/2012	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0	25.00

		Urban/Rural S 1.00	Date of Geogr 2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet S-2 Part I Date/Time Prepared: 2/20/2013 1:52 pm

		Beginning: 1.00	Ending: 2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00

		Y/N 1.00	
39.00	Does this facility qualify for the Inpatient Hospital Payment Adjustment for Low Volume Hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no.		39.00

		V 1.00	XVIII 2.00	XIX 3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N 1.00	IME Average 2.00	Direct GME Average 3.00	
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00	61.00
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)				
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01
	Teaching Hospitals that Claim Residents in Non-Provider Settings				
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N			63.00

		Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet S-2 Part I | Date/Time Prepared: 2/20/2013 1:52 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	If line 63 is yes, then, for each primary care residency program in which you are training residents, enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.			0.00	0.00	0.000000	67.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	76.00

		1.00		
	Long Term Care Hospital PPS			
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00
	TEFRA Providers			
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N	N	107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0			118.00

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	0	118.01
			1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		121.00
	Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
	All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		N		140.00
		1.00	2.00	3.00	

If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.

141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	N	145.00
		1.00	2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00

Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)

		Part A 1.00	Part B 2.00	Title V 3.00	Title XIX 4.00	
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

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1.00

Multicampus

165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no. — N — 165.00

	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1.00	2.00	3.00	4.00	5.00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00

1.00

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

167.00 Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no. — Y — 167.00

168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions) — 54,512 — 168.00

169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions) — 0.00 — 169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet S-2 Part II | Date/Time Prepared: 2/20/2013 1:52 pm

General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.

COMPLETED BY ALL HOSPITALS

		Y/N 1.00	Date 2.00		
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N 1.00	Date 2.00	V/I 3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N 1.00	Type 2.00	Date 3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C	03/01/2011	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
		Y/N 1.00	Legal Oper. 2.00		
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N 1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00

		Part A			
	Description 0	Y/N 1.00	Date 2.00		
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	01/03/2013		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N			20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet S-2 Part II | Date/Time Prepared: 2/20/2013 1:52 pm

Part A

		Description	Y/N	Date	
		0	1.00	2.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JAKE	CARNAZZO	41.00
42.00	Enter the employer/company name of the cost report preparer.	ALLIANT MANAGEMENT SERVICES		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5029923476	JCARNAZZO@ALLIANTMANAGEMENT.COM	43.00

		Part B Y/N 3.00	Part B Date 4.00	
	PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	01/03/2013	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00
			3.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		REIMBURSEMENT MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet S-3 Part I | Date/Time Prepared: 2/20/2013 1:52 pm

	Cost Center Description	Worksheet A Line Number 1.00	No. of Beds 2.00	Bed Days Available 3.00	CAH Hours 4.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	20	7,320	44,976.00		1.00
2.00	HMO						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		20	7,320	44,976.00		7.00
8.00	INTENSIVE CARE UNIT	31.00	5	1,830	9,792.00		8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,150	54,768.00		14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	45	16,470			19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		70				27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet S-3 Part I | Date/Time Prepared: 2/20/2013 1:52 pm

I/P Days / O/P Visits / Trips

	Cost Center Description	Title V	Title XVIII	Title XIX	Total All Patients	
		5.00	6.00	7.00	8.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	1,258	74	1,874	1.00
2.00	HMO		334	0		2.00
3.00	HMO IPF Subprovider		0	0		3.00
4.00	HMO IRF Subprovider		0	0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	698	0	698	5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0		121	121	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	0	1,956	195	2,693	7.00
8.00	INTENSIVE CARE UNIT	0	188	0	408	8.00
9.00	CORONARY CARE UNIT					9.00
10.00	BURN INTENSIVE CARE UNIT					10.00
11.00	SURGICAL INTENSIVE CARE UNIT					11.00
12.00	OTHER SPECIAL CARE (SPECIFY)					12.00
13.00	NURSERY					13.00
14.00	Total (see instructions)	0	2,144	195	3,101	14.00
15.00	CAH visits	0	0	0	0	15.00
16.00	SUBPROVIDER - IPF					16.00
17.00	SUBPROVIDER - IRF					17.00
18.00	SUBPROVIDER					18.00
19.00	SKILLED NURSING FACILITY	0	1,937	0	12,172	19.00
20.00	NURSING FACILITY					20.00
21.00	OTHER LONG TERM CARE					21.00
22.00	HOME HEALTH AGENCY	0	3,060	171	4,156	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00	HOSPICE					24.00
25.00	CMHC - CMHC					25.00
26.00	RURAL HEALTH CLINIC					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER					26.25
27.00	Total (sum of lines 14-26)					27.00
28.00	Observation Bed Days	0		0	536	28.00
29.00	Ambulance Trips		0			29.00
30.00	Employee discount days (see instruction)				0	30.00
31.00	Employee discount days - IRF				0	31.00
32.00	Labor & delivery days (see instructions)			0	0	32.00
33.00	LTCH non-covered days		0			33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet S-3 Part I | Date/Time Prepared: 2/20/2013 1:52 pm

	Cost Center Description	Full Time Equivalents: Total Interns & Residents 9.00	Full Time Equivalents: Employees On Payroll 10.00	Full Time Equivalents: Nonpaid Workers 11.00	Discharges: Title V 12.00	Discharges: Title XVIII 13.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	398	1.00
2.00	HMO					78	2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	259.75	0.00	0	398	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00	30.39	0.00			19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00	4.88	0.00			22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00	295.02	0.00			27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet S-3 Part I | Date/Time Prepared: 2/20/2013 1:52 pm

	Cost Center Description	Discharges Title XIX	Discharges Total All Patients	
		14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	34	641	1.00
2.00	HMO			2.00
3.00	HMO IPF Subprovider			3.00
4.00	HMO IRF Subprovider			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF			5.00
6.00	Hospital Adults & Peds. Swing Bed NF			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)			7.00
8.00	INTENSIVE CARE UNIT			8.00
9.00	CORONARY CARE UNIT			9.00
10.00	BURN INTENSIVE CARE UNIT			10.00
11.00	SURGICAL INTENSIVE CARE UNIT			11.00
12.00	OTHER SPECIAL CARE (SPECIFY)			12.00
13.00	NURSERY			13.00
14.00	Total (see instructions)	34	641	14.00
15.00	CAH visits			15.00
16.00	SUBPROVIDER - IPF			16.00
17.00	SUBPROVIDER - IRF			17.00
18.00	SUBPROVIDER			18.00
19.00	SKILLED NURSING FACILITY			19.00
20.00	NURSING FACILITY			20.00
21.00	OTHER LONG TERM CARE			21.00
22.00	HOME HEALTH AGENCY			22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)			23.00
24.00	HOSPICE			24.00
25.00	CMHC - CMHC			25.00
26.00	RURAL HEALTH CLINIC			26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER			26.25
27.00	Total (sum of lines 14-26)			27.00
28.00	Observation Bed Days			28.00
29.00	Ambulance Trips			29.00
30.00	Employee discount days (see instruction)			30.00
31.00	Employee discount days - IRF			31.00
32.00	Labor & delivery days (see instructions)			32.00
33.00	LTCH non-covered days			33.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 151319 | Component CCN: 157445 | Period: From 10/01/2011 To 09/30/2012 | Worksheet S-4 | Date/Time Prepared: 2/20/2013 1:52 pm

Home Health Agency I | PPS

					1.00		
0.00	County				GIBSON		0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	146.00	0.00	17.00	163.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		0.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			0.00	0.00	0.00	5.00
6.00	Direct Nursing Service			0.00	0.00	0.00	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			21780			20.00
		Full Episodes Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,265	30	35	28	1,358	21.00
22.00	Skilled Nursing Visit Charges	163,640	3,881	4,528	3,622	175,671	22.00
23.00	Physical Therapy Visits	863	0	13	38	914	23.00
24.00	Physical Therapy Visit Charges	113,674	0	1,712	5,005	120,391	24.00
25.00	Occupational Therapy Visits	143	0	2	0	145	25.00
26.00	Occupational Therapy Visit Charges	18,836	0	263	0	19,099	26.00
27.00	Speech Pathology Visits	28	0	0	0	28	27.00
28.00	Speech Pathology Visit Charges	3,688	0	0	0	3,688	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	582	25	6	2	615	31.00
32.00	Home Health Aide Visit Charges	42,125	1,810	434	145	44,514	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,881	55	56	68	3,060	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	341,963	5,691	6,937	8,772	363,363	35.00
36.00	Total Number of Episodes (standard/non outlier)	148		19	6	173	36.00
37.00	Total Number of Outlier Episodes		1		0	1	37.00
38.00	Total Non-Routine Medical Supply Charges	2,047	39	41	267	2,394	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet S-7 | Date/Time Prepared: 2/20/2013 1:52 pm

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	12/16/2003	2.00

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1.00	2.00	3.00	4.00	
3.00	RUX	0	0	0	3.00
4.00	RUL	0	0	0	4.00
5.00	RVX	0	0	0	5.00
6.00	RVL	0	0	0	6.00
7.00	RHX	0	0	0	7.00
8.00	RHL	0	0	0	8.00
9.00	RMX	0	0	0	9.00
10.00	RML	0	0	0	10.00
11.00	RLX	0	0	0	11.00
12.00	RUC	0	0	0	12.00
13.00	RUB	0	0	0	13.00
14.00	RUA	0	0	0	14.00
15.00	RVC	28	0	28	15.00
16.00	RVB	35	0	35	16.00
17.00	RVA	72	0	72	17.00
18.00	RHC	138	0	138	18.00
19.00	RHB	497	0	497	19.00
20.00	RHA	437	0	437	20.00
21.00	RMC	119	0	119	21.00
22.00	RMB	124	0	124	22.00
23.00	RMA	257	0	257	23.00
24.00	RLB	0	0	0	24.00
25.00	RLA	4	0	4	25.00
26.00	ES3	0	0	0	26.00
27.00	ES2	0	0	0	27.00
28.00	ES1	0	0	0	28.00
29.00	HE2	0	0	0	29.00
30.00	HE1	0	0	0	30.00
31.00	HD2	8	0	8	31.00
32.00	HD1	18	0	18	32.00
33.00	HC2	18	0	18	33.00
34.00	HC1	32	0	32	34.00
35.00	HB2	0	0	0	35.00
36.00	HB1	1	0	1	36.00
37.00	LE2	0	0	0	37.00
38.00	LE1	0	0	0	38.00
39.00	LD2	0	0	0	39.00
40.00	LD1	0	0	0	40.00
41.00	LC2	0	0	0	41.00
42.00	LC1	11	0	11	42.00
43.00	LB2	0	0	0	43.00
44.00	LB1	0	0	0	44.00
45.00	CE2	0	0	0	45.00
46.00	CE1	2	0	2	46.00
47.00	CD2	3	0	3	47.00
48.00	CD1	49	0	49	48.00
49.00	CC2	0	0	0	49.00
50.00	CC1	23	0	23	50.00
51.00	CB2	0	0	0	51.00
52.00	CB1	27	0	27	52.00
53.00	CA2	13	0	13	53.00
54.00	CA1	21	0	21	54.00
55.00	SE3	0	0	0	55.00
56.00	SE2	0	0	0	56.00
57.00	SE1	0	0	0	57.00
58.00	SSC	0	0	0	58.00
59.00	SSB	0	0	0	59.00
60.00	SSA	0	0	0	60.00
61.00	IB2	0	0	0	61.00
62.00	IB1	0	0	0	62.00
63.00	IA2	0	0	0	63.00
64.00	IA1	0	0	0	64.00
65.00	BB2	0	0	0	65.00
66.00	BB1	0	0	0	66.00
67.00	BA2	0	0	0	67.00
68.00	BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet S-7 | Date/Time Prepared: 2/20/2013 1:52 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		1,937	0	1,937	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	21780	21780	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	0	0.00		202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	1,972,579			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet S-10 | Date/Time Prepared: 2/20/2013 1:52 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.444774	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,074,916	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	6,049,122	6.00
7.00	Medicaid cost (line 1 times line 6)	2,690,492	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	615,576	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	615,576	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	481,472	1,378,507	1,859,979	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	214,146	613,124	827,270	21.00
22.00	Partial payment by patients approved for charity care	34,772	17,502	52,274	22.00
23.00	Cost of charity care (line 21 minus line 22)	179,374	595,622	774,996	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	3,573,591	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	176,773	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	3,396,818	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	1,510,816	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	2,285,812	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,901,388	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet A | Date/Time Prepared: 2/20/2013 1:52 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,703,015	1,703,015	-636,023	1,066,992	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	1,292,310	1,292,310	2.00
4.00	00400	EMPLOYEE BENEFITS	145,751	-277,166	-131,415	618,305	486,890	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,684,107	3,771,476	5,455,583	-84,044	5,371,539	5.00
7.00	00700	OPERATION OF PLANT	274,588	903,742	1,178,330	-20,478	1,157,852	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	36,222	57,020	93,242	-1,582	91,660	8.00
9.00	00900	HOUSEKEEPING	320,715	187,484	508,199	-16,837	491,362	9.00
10.00	01000	DIETARY	378,877	392,284	771,161	-443,248	327,913	10.00
11.00	01100	CAFETERIA	0	0	0	424,951	424,951	11.00
13.00	01300	NURSING ADMINISTRATION	144,772	26,054	170,826	0	170,826	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	225,867	208,168	434,035	-9,206	424,829	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,140,196	544,103	1,684,299	-99,325	1,584,974	30.00
31.00	03100	INTENSIVE CARE UNIT	309,125	61,975	371,100	-9,017	362,083	31.00
44.00	04400	SKILLED NURSING FACILITY	1,109,683	504,087	1,613,770	-67,743	1,546,027	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	568,678	1,552,589	2,121,267	-593,216	1,528,051	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	635,561	667,870	1,303,431	-62,973	1,240,458	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	136,343	136,343	-13	136,330	54.03
60.00	06000	LABORATORY	650,030	857,976	1,508,006	-65,125	1,442,881	60.00
65.00	06500	RESPIRATORY THERAPY	338,984	406,030	745,014	-51,133	693,881	65.00
66.00	06600	PHYSICAL THERAPY	642,589	208,461	851,050	-41,660	809,390	66.00
67.00	06700	OCCUPATIONAL THERAPY	237,585	62,881	300,466	-6,390	294,076	67.00
68.00	06800	SPEECH PATHOLOGY	133,145	58,746	191,891	-7,544	184,347	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	-652	-652	148,269	147,617	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	496,258	496,258	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	246,976	701,648	948,624	-49,076	899,548	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	162,993	217,353	380,346	-17,968	362,378	90.00
90.01	09001	DIABETES	35,768	15,009	50,777	-117	50,660	90.01
90.02	09002	OP PSYCH	51,623	74,240	125,863	-1,874	123,989	90.02
91.00	09100	EMERGENCY	737,673	638,675	1,376,348	-61,562	1,314,786	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	CARDIAC REHAB	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	235,562	138,100	373,662	-14,020	359,642	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		309,856	309,856	-309,856	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,447,070	14,127,367	24,574,437	310,063	24,884,500	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	3,687,788	2,693,244	6,381,032	-207,193	6,173,839	194.00
194.01	07951	FOUNDATION	46,807	17,472	64,279	-102,870	-38,591	194.01
194.02	07952	ASC	0	241,079	241,079	0	241,079	194.02
200.00		TOTAL (SUM OF LINES 118-199)	14,181,665	17,079,162	31,260,827	0	31,260,827	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet A | Date/Time Prepared: 2/20/2013 1:52 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	0	1,066,992	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-96,724	1,195,586	2.00
4.00	00400	EMPLOYEE BENEFITS	111,578	598,468	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-378,410	4,993,129	5.00
7.00	00700	OPERATION OF PLANT	-9,785	1,148,067	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	91,660	8.00
9.00	00900	HOUSEKEEPING	0	491,362	9.00
10.00	01000	DIETARY	0	327,913	10.00
11.00	01100	CAFETERIA	-177,689	247,262	11.00
13.00	01300	NURSING ADMINISTRATION	0	170,826	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-10,654	414,175	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	1,584,974	30.00
31.00	03100	INTENSIVE CARE UNIT	0	362,083	31.00
44.00	04400	SKILLED NURSING FACILITY	0	1,546,027	44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	-523,083	1,004,968	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,240,458	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	136,330	54.03
60.00	06000	LABORATORY	0	1,442,881	60.00
65.00	06500	RESPIRATORY THERAPY	-26,500	667,381	65.00
66.00	06600	PHYSICAL THERAPY	0	809,390	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	294,076	67.00
68.00	06800	SPEECH PATHOLOGY	0	184,347	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	147,617	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	496,258	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	899,548	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	362,378	90.00
90.01	09001	DIABETES	0	50,660	90.01
90.02	09002	OP PSYCH	-57,789	66,200	90.02
91.00	09100	EMERGENCY	0	1,314,786	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
93.00	04040	CARDIAC REHAB	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0	359,642	101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,169,056	23,715,444	118.00
		NONREIMBURSABLE COST CENTERS			
194.00	07950	MOB	0	6,173,839	194.00
194.01	07951	FOUNDATION	0	-38,591	194.01
194.02	07952	ASC	0	241,079	194.02
200.00		TOTAL (SUM OF LINES 118-199)	-1,169,056	30,091,771	200.00

RECLASSIFICATIONS | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet A-6 | Date/Time Prepared: 2/20/2013 1:52 pm

	Cost Center 2.00	Increases Line # 3.00	Salary 4.00	Other 5.00	
	A - INSURANCE				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	22,464	1.00
	TOTALS		0	22,464	
	B - DEPRECIATION				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	611,478	1.00
	TOTALS		0	611,478	
	D - CAFETERIA				
1.00	CAFETERIA	11.00	208,781	216,170	1.00
	TOTALS		208,781	216,170	
	E - MED SUPPLY CHG PTS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	148,269	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	496,258	2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	34	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0	356	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
	TOTALS		0	644,917	
	F - RENTAL EXPENSE				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	347,129	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
24.00		0.00	0	0	24.00
27.00		0.00	0	0	27.00
	TOTALS		0	347,129	
	H - BUSINESS HEALTH SER				
1.00	EMPLOYEE BENEFITS	4.00	32,372	29,692	1.00
	TOTALS		32,372	29,692	
	I - INTEREST				
1.00		0.00	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	309,158	2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	698	3.00
	TOTALS		0	309,856	
	J - PROPERTY TAX				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2,081	1.00
	TOTALS		0	2,081	
	K - QUALITY SERVICES				
1.00	ADMINISTRATIVE & GENERAL	5.00	28,207	3,183	1.00
	TOTALS		28,207	3,183	
	L - HEALTH INSURANCE				
1.00	EMPLOYEE BENEFITS	4.00	0	556,241	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00

RECLASSIFICATIONS | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet A-6 | Date/Time Prepared: 2/20/2013 1:52 pm

	Cost Center 2.00	Increases Line # 3.00	Salary 4.00	Other 5.00	
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
28.00		0.00	0	0	28.00
30.00		0.00	0	0	30.00
	TOTALS		0	556,241	
500.00	Grand Total: Increases		269,360	2,743,211	500.00

	Cost Center 6.00	Decreases Line # 7.00	Salary 8.00	Other 9.00	Wkst. A-7 Ref. 10.00		
	A - INSURANCE						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	22,464	9		1.00
	TOTALS		0	22,464			
	B - DEPRECIATION						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	611,478	9		1.00
	TOTALS		0	611,478			
	D - CAFETERIA						
1.00	DIETARY	10.00	208,781	216,170	0		1.00
	TOTALS		208,781	216,170			
	E - MED SUPPLY CHG PTS						
1.00		0.00	0	0	0		1.00
2.00	DIETARY	10.00	0	116	0		2.00
3.00		0.00	0	0	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	1,197	0		4.00
5.00	INTENSIVE CARE UNIT	31.00	0	234	0		5.00
6.00	SKILLED NURSING FACILITY	44.00	0	1,664	0		6.00
7.00	OPERATING ROOM	50.00	0	527,406	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,613	0		8.00
9.00	NUCLEAR MEDICINE-DIAGNOSTIC	54.03	0	13	0		9.00
10.00	LABORATORY	60.00	0	3,308	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	13,410	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	4,155	0		12.00
13.00	EMERGENCY	91.00	0	7,257	0		13.00
14.00	HOME HEALTH AGENCY	101.00	0	699	0		14.00
15.00	MOB	194.00	0	83,845	0		15.00
	TOTALS		0	644,917			
	F - RENTAL EXPENSE						
1.00		0.00	0	0	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	30,260	0		2.00
3.00	OPERATION OF PLANT	7.00	0	1,678	0		3.00
5.00	HOUSEKEEPING	9.00	0	191	0		5.00
6.00	DIETARY	10.00	0	764	0		6.00
9.00	ADULTS & PEDIATRICS	30.00	0	21,032	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	5,217	0		10.00
11.00	SKILLED NURSING FACILITY	44.00	0	1,530	0		11.00
12.00	OPERATING ROOM	50.00	0	48,335	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	31,474	0		13.00
15.00	LABORATORY	60.00	0	32,820	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	28,514	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	22,140	0		17.00
21.00	DRUGS CHARGED TO PATIENTS	73.00	0	45,645	0		21.00
22.00	CLINIC	90.00	0	5,810	0		22.00
24.00	EMERGENCY	91.00	0	10,435	0		24.00
27.00	MOB	194.00	0	61,284	0		27.00
	TOTALS		0	347,129			
	H - BUSINESS HEALTH SER						
1.00	MOB	194.00	32,372	29,692	0		1.00
	TOTALS		32,372	29,692			
	I - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	309,856	0		1.00
2.00		0.00	0	0	9		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	309,856			
	J - PROPERTY TAX						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	2,081	9		1.00
	TOTALS		0	2,081			
	K - QUALITY SERVICES						
1.00	ADULTS & PEDIATRICS	30.00	28,207	3,183	0		1.00
	TOTALS		28,207	3,183			
	L - HEALTH INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	85,906	0		1.00
2.00	OPERATION OF PLANT	7.00	0	18,800	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	1,582	0		3.00
4.00	HOUSEKEEPING	9.00	0	16,646	0		4.00
5.00	DIETARY	10.00	0	17,417	0		5.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	9,206	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	45,706	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	3,566	0		10.00
11.00	SKILLED NURSING FACILITY	44.00	0	64,549	0		11.00
12.00	OPERATING ROOM	50.00	0	17,475	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	29,886	0		13.00

RECLASSIFICATIONS | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet A-6 | Date/Time Prepared: 2/20/2013 1:52 pm

	Cost Center 6.00	Decreases Line # 7.00	Salary 8.00	Other 9.00	Wkst. A-7 Ref. 10.00		
15.00	LABORATORY	60.00	0	28,997	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	9,209	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	15,365	0		17.00
18.00	OCCUPATIONAL THERAPY	67.00	0	6,390	0		18.00
19.00	SPEECH PATHOLOGY	68.00	0	7,544	0		19.00
22.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,787	0		22.00
23.00	CLINIC	90.00	0	12,158	0		23.00
24.00	DIABETES	90.01	0	117	0		24.00
25.00	OP PSYCH	90.02	0	1,874	0		25.00
26.00	EMERGENCY	91.00	0	43,870	0		26.00
28.00	HOME HEALTH AGENCY	101.00	0	13,321	0		28.00
30.00	FOUNDATION	194.01	0	102,870	0		30.00
	TOTALS		0	556,241			
500.00	Grand Total: Decreases		269,360	2,743,211			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet A-7 Parts I-III | Date/Time Prepared: 2/20/2013 1:52 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	653,693	0	0	0	3,732	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	18,005,243	0	0	0	681,095	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	12,630,437	0	0	0	644,426	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	31,289,373	0	0	0	1,329,253	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	31,289,373	0	0	0	1,329,253	10.00

SUMMARY OF CAPITAL

	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,703,015	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,703,015	0	0	0	0	3.00

COMPUTATION OF RATIOS

	Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,703,015	0	1,703,015	1.000000	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	1,703,015	0	1,703,015	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet A-7 Parts I-III | Date/Time Prepared: 2/20/2013 1:52 pm

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	649,961	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	17,324,148	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	11,986,011	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	29,960,120	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	29,960,120	0	10.00

SUMMARY OF CAPITAL

	Cost Center Description	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,703,015	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	1,703,015	3.00

ALLOCATION OF OTHER CAPITAL

	Cost Center Description	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,066,992	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,292,310	-96,724	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,359,302	-96,724	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet A-7 Parts I-III | Date/Time Prepared: 2/20/2013 1:52 pm

	Cost Center Description	SUMMARY OF CAPITAL Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,066,992	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,195,586	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	2,262,578	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet A-8 | Date/Time Prepared: 2/20/2013 1:52 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	
		1.00	2.00	3.00	4.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-96,724	NEW CAP REL COSTS-MVBLE EQUIP	2.00	2.00
3.00	Investment income - other (chapter 2)		0		0.00	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-9,785	OPERATION OF PLANT	7.00	7.00
8.00	Television and radio service (chapter 21)		0		0.00	8.00
9.00	Parking lot (chapter 21)		0		0.00	9.00
10.00	Provider-based physician adjustment	A-8-2	-607,372			10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			12.00
13.00	Laundry and linen service		0		0.00	13.00
14.00	Cafeteria-employees and guests	B	-177,689	CAFETERIA	11.00	14.00
15.00	Rental of quarters to employee and others	B	-600	ADMINISTRATIVE & GENERAL	5.00	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	16.00
17.00	Sale of drugs to other than patients		0		0.00	17.00
18.00	Sale of medical records and abstracts	B	-10,654	MEDICAL RECORDS & LIBRARY	16.00	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	19.00
20.00	Vending machines		0		0.00	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00	23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00	24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00	25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00	28.00
29.00	Physicians' assistant		0		0.00	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00	30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00	31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	32.00
33.00	MISC INCOME	B	-50,702	ADMINISTRATIVE & GENERAL	5.00	33.00
33.01			0		0.00	33.01
33.02	PHYSICIAN RECRUITING	A	-56,053	ADMINISTRATIVE & GENERAL	5.00	33.02
33.03	ADVERTISING	A	-271,055	ADMINISTRATIVE & GENERAL	5.00	33.03
34.00	EMPLOYEE DISCOUNT	A	111,578	EMPLOYEE BENEFITS	4.00	34.00
35.00			0		0.00	35.00
36.00			0		0.00	36.00
37.00			0		0.00	37.00
38.00			0		0.00	38.00
39.00			0		0.00	39.00
40.00			0		0.00	40.00
41.00			0		0.00	41.00
42.00			0		0.00	42.00
43.00			0		0.00	43.00
44.00			0		0.00	44.00
45.00			0		0.00	45.00

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	
		1.00	2.00	3.00	4.00	
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,169,056			50.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet A-8 | Date/Time Prepared: 2/20/2013 1:52 pm

	Cost Center Description	Wkst. A-7 Ref. 5.00		
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	0		1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	10		2.00
3.00	Investment income - other (chapter 2)	0		3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0		4.00
5.00	Refunds and rebates of expenses (chapter 8)	0		5.00
6.00	Rental of provider space by suppliers (chapter 8)	0		6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0		7.00
8.00	Television and radio service (chapter 21)	0		8.00
9.00	Parking lot (chapter 21)	0		9.00
10.00	Provider-based physician adjustment	0		10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0		11.00
12.00	Related organization transactions (chapter 10)	0		12.00
13.00	Laundry and linen service	0		13.00
14.00	Cafeteria-employees and guests	0		14.00
15.00	Rental of quarters to employee and others	0		15.00
16.00	Sale of medical and surgical supplies to other than patients	0		16.00
17.00	Sale of drugs to other than patients	0		17.00
18.00	Sale of medical records and abstracts	0		18.00
19.00	Nursing school (tuition, fees, books, etc.)	0		19.00
20.00	Vending machines	0		20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0		21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0		22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)			23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)			24.00
25.00	Utilization review - physicians' compensation (chapter 21)			25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT	0		26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP	0		27.00
28.00	Non-physician Anesthetist			28.00
29.00	Physicians' assistant	0		29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)			30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)			31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0		32.00
33.00	MISC INCOME	0		33.00
33.01		0		33.01
33.02	PHYSICIAN RECRUITING	0		33.02
33.03	ADVERTISING	0		33.03
34.00	EMPLOYEE DISCOUNT	0		34.00
35.00		0		35.00
36.00		0		36.00
37.00		0		37.00
38.00		0		38.00
39.00		0		39.00
40.00		0		40.00
41.00		0		41.00
42.00		0		42.00
43.00		0		43.00
44.00		0		44.00
45.00		0		45.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)			50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet A-8-2 | Date/Time Prepared: 2/20/2013 1:52 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	50.00	OPERATING ROOM	523,083	523,083	1.00
2.00	65.00	RESPIRATORY THERAPY	81,500	26,500	2.00
3.00	90.00	CLINIC	38,836	0	3.00
4.00	90.02	OP PSYCH	57,789	57,789	4.00
5.00	91.00	EMERGENCY	207,833	0	5.00
6.00	0.00		0	0	6.00
7.00	0.00		0	0	7.00
8.00	0.00		0	0	8.00
9.00	0.00		0	0	9.00
10.00	0.00		0	0	10.00
200.00			909,041	607,372	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet A-8-2 | Date/Time Prepared: 2/20/2013 1:52 pm

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	0	0	0	0	0	1.00
2.00	55,000	0	0	0	0	2.00
3.00	38,836	0	0	0	0	3.00
4.00	0	0	0	0	0	4.00
5.00	207,833	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	301,669		0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet A-8-2 | Date/Time Prepared: 2/20/2013 1:52 pm

	Cost of Memberships & Continuing Education 12.00	Provider Component Share of col. 12 13.00	Physician Cost of Malpractice Insurance 14.00	Provider Component Share of col. 14 15.00	Adjusted RCE Limit 16.00	
1.00	0	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	0	0	0	0	0	3.00
4.00	0	0	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	0	0	0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet A-8-2 | Date/Time Prepared: 2/20/2013 1:52 pm

		RCE Disallowance 17.00	Adjustment 18.00		
1.00		0	523,083		1.00
2.00		0	26,500		2.00
3.00		0	0		3.00
4.00		0	57,789		4.00
5.00		0	0		5.00
6.00		0	0		6.00
7.00		0	0		7.00
8.00		0	0		8.00
9.00		0	0		9.00
10.00		0	0		10.00
200.00		0	607,372		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet B Part I Date/Time Prepared: 2/20/2013 1:52 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1,066,992	1,066,992				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	1,195,586		1,195,586			2.00
4.00	00400	EMPLOYEE BENEFITS	598,468	6,567	7,359	612,394		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,993,129	52,038	58,309	74,881	5,178,357	5.00
7.00	00700	OPERATION OF PLANT	1,148,067	176,991	198,322	12,008	1,535,388	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	91,660	18,980	21,268	1,584	133,492	8.00
9.00	00900	HOUSEKEEPING	491,362	10,713	12,004	14,025	528,104	9.00
10.00	01000	DIETARY	327,913	48,731	54,604	7,438	438,686	10.00
11.00	01100	CAFETERIA	247,262	0	0	9,130	256,392	11.00
13.00	01300	NURSING ADMINISTRATION	170,826	3,214	3,601	6,331	183,972	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	414,175	15,522	17,392	9,877	456,966	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,584,974	95,273	106,755	48,628	1,835,630	30.00
31.00	03100	INTENSIVE CARE UNIT	362,083	22,543	25,260	13,518	423,404	31.00
44.00	04400	SKILLED NURSING FACILITY	1,546,027	111,039	124,421	48,528	1,830,015	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,004,968	59,432	66,595	24,869	1,155,864	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,240,458	40,708	45,614	27,794	1,354,574	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	136,330	4,891	5,480	0	146,701	54.03
60.00	06000	LABORATORY	1,442,881	17,816	19,963	28,426	1,509,086	60.00
65.00	06500	RESPIRATORY THERAPY	667,381	18,770	21,033	14,824	722,008	65.00
66.00	06600	PHYSICAL THERAPY	809,390	32,732	36,677	28,101	906,900	66.00
67.00	06700	OCCUPATIONAL THERAPY	294,076	9,525	10,673	10,390	324,664	67.00
68.00	06800	SPEECH PATHOLOGY	184,347	722	809	5,823	191,701	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	147,617	41,791	46,828	0	236,236	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	496,258	0	0	0	496,258	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	899,548	11,784	13,204	10,801	935,337	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	362,378	25,035	28,052	7,128	422,593	90.00
90.01	09001	DIABETES	50,660	16,279	18,240	1,564	86,743	90.01
90.02	09002	OP PSYCH	66,200	2,340	2,623	2,258	73,421	90.02
91.00	09100	EMERGENCY	1,314,786	103,039	115,458	32,259	1,565,542	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
93.00	04040	CARDIAC REHAB	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	359,642	5,880	6,589	10,301	382,412	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	23,715,444	952,355	1,067,133	450,486	23,310,446	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	6,173,839	99,395	111,374	159,861	6,544,469	194.00
194.01	07951	FOUNDATION	-38,591	15,242	17,079	2,047	-4,223	194.01
194.02	07952	ASC	241,079	0	0	0	241,079	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	30,091,771	1,066,992	1,195,586	612,394	30,091,771	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet B Part I | Date/Time Prepared: 2/20/2013 1:52 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL 5.00	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,178,357					5.00
7.00	00700	OPERATION OF PLANT	319,083	1,854,471				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	27,742	42,336	203,570			8.00
9.00	00900	HOUSEKEEPING	109,750	23,895	9,152	670,901		9.00
10.00	01000	DIETARY	91,167	108,697	2,722	40,780	682,052	10.00
11.00	01100	CAFETERIA	53,283	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	38,233	7,169	0	2,689	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	94,966	34,622	0	12,989	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	381,479	212,511	68,543	79,729	239,952	30.00
31.00	03100	INTENSIVE CARE UNIT	87,991	50,284	979	18,865	0	31.00
44.00	04400	SKILLED NURSING FACILITY	380,312	247,677	62,374	92,924	442,100	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	240,211	132,566	14,242	49,735	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	281,506	90,802	9,192	34,066	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	30,487	10,909	0	4,093	0	54.03
60.00	06000	LABORATORY	313,617	39,739	0	14,909	0	60.00
65.00	06500	RESPIRATORY THERAPY	150,047	41,868	4,466	15,708	0	65.00
66.00	06600	PHYSICAL THERAPY	188,471	73,010	14,394	27,391	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	67,471	21,246	0	7,971	0	67.00
68.00	06800	SPEECH PATHOLOGY	39,839	1,610	0	604	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	49,094	93,217	0	34,973	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	103,132	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	194,381	26,285	0	9,861	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	87,823	55,842	0	20,950	0	90.00
90.01	09001	DIABETES	18,027	36,310	0	13,623	0	90.01
90.02	09002	OP PSYCH	15,258	5,221	0	1,959	0	90.02
91.00	09100	EMERGENCY	325,349	229,835	17,506	86,228	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	CARDIAC REHAB	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	79,472	13,116	0	4,921	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,768,191	1,598,767	203,570	574,968	682,052	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	1,360,065	221,705	0	83,178	0	194.00
194.01	07951	FOUNDATION	0	33,999	0	12,755	0	194.01
194.02	07952	ASC	50,101	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	5,178,357	1,854,471	203,570	670,901	682,052	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet B Part I Date/Time Prepared: 2/20/2013 1:52 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			11.00	13.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	309,675					11.00
13.00	01300	NURSING ADMINISTRATION	2,035	234,098				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	15,176	0	614,719			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	52,226	78,534	174,484	3,123,088	0	30.00
31.00	03100	INTENSIVE CARE UNIT	10,895	16,384	9,395	618,197	0	31.00
44.00	04400	SKILLED NURSING FACILITY	61,823	92,962	2,684	3,212,871	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,522	0	67,109	1,674,249	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,165	0	63,083	1,858,388	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	192,190	0	54.03
60.00	06000	LABORATORY	28,789	0	73,820	1,979,960	0	60.00
65.00	06500	RESPIRATORY THERAPY	12,734	0	22,817	969,648	0	65.00
66.00	06600	PHYSICAL THERAPY	25,072	0	42,950	1,278,188	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,756	0	0	429,108	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,585	0	0	237,339	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,057	0	0	415,577	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	599,390	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,030	0	0	1,171,894	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,040	0	2,684	591,932	0	90.00
90.01	09001	DIABETES	2,542	3,822	0	161,067	0	90.01
90.02	09002	OP PSYCH	7,262	0	0	103,121	0	90.02
91.00	09100	EMERGENCY	28,194	42,396	153,009	2,448,059	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
93.00	04040	CARDIAC REHAB	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	1,342	481,263	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	307,903	234,098	613,377	21,545,529	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	0	0	1,342	8,210,759	0	194.00
194.01	07951	FOUNDATION	1,772	0	0	44,303	0	194.01
194.02	07952	ASC	0	0	0	291,180	0	194.02
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	309,675	234,098	614,719	30,091,771	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet B Part I Date/Time Prepared: 2/20/2013 1:52 pm

		Cost Center Description	Total 26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	3,123,088		30.00
31.00	03100	INTENSIVE CARE UNIT	618,197		31.00
44.00	04400	SKILLED NURSING FACILITY	3,212,871		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	1,674,249		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,858,388		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	192,190		54.03
60.00	06000	LABORATORY	1,979,960		60.00
65.00	06500	RESPIRATORY THERAPY	969,648		65.00
66.00	06600	PHYSICAL THERAPY	1,278,188		66.00
67.00	06700	OCCUPATIONAL THERAPY	429,108		67.00
68.00	06800	SPEECH PATHOLOGY	237,339		68.00
69.00	06900	ELECTROCARDIOLOGY	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	415,577		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	599,390		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,171,894		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	591,932		90.00
90.01	09001	DIABETES	161,067		90.01
90.02	09002	OP PSYCH	103,121		90.02
91.00	09100	EMERGENCY	2,448,059		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
93.00	04040	CARDIAC REHAB	0		93.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	481,263		101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	21,545,529		118.00
		NONREIMBURSABLE COST CENTERS			
194.00	07950	MOB	8,210,759		194.00
194.01	07951	FOUNDATION	44,303		194.01
194.02	07952	ASC	291,180		194.02
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	30,091,771		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet B Part II | Date/Time Prepared: 2/20/2013 1:52 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS	0	6,567	7,359	13,926	13,926	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	52,038	58,309	110,347	1,702	5.00
7.00	00700	OPERATION OF PLANT	0	176,991	198,322	375,313	273	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	18,980	21,268	40,248	36	8.00
9.00	00900	HOUSEKEEPING	0	10,713	12,004	22,717	319	9.00
10.00	01000	DIETARY	0	48,731	54,604	103,335	169	10.00
11.00	01100	CAFETERIA	0	0	0	0	208	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,214	3,601	6,815	144	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	15,522	17,392	32,914	225	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	95,273	106,755	202,028	1,105	30.00
31.00	03100	INTENSIVE CARE UNIT	0	22,543	25,260	47,803	307	31.00
44.00	04400	SKILLED NURSING FACILITY	0	111,039	124,421	235,460	1,103	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	59,432	66,595	126,027	565	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	40,708	45,614	86,322	632	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	4,891	5,480	10,371	0	54.03
60.00	06000	LABORATORY	0	17,816	19,963	37,779	646	60.00
65.00	06500	RESPIRATORY THERAPY	0	18,770	21,033	39,803	337	65.00
66.00	06600	PHYSICAL THERAPY	0	32,732	36,677	69,409	639	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	9,525	10,673	20,198	236	67.00
68.00	06800	SPEECH PATHOLOGY	0	722	809	1,531	132	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	41,791	46,828	88,619	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,784	13,204	24,988	245	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	25,035	28,052	53,087	162	90.00
90.01	09001	DIABETES	0	16,279	18,240	34,519	36	90.01
90.02	09002	OP PSYCH	0	2,340	2,623	4,963	51	90.02
91.00	09100	EMERGENCY	0	103,039	115,458	218,497	733	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
93.00	04040	CARDIAC REHAB	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	5,880	6,589	12,469	234	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	952,355	1,067,133	2,019,488	10,239	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	0	99,395	111,374	210,769	3,640	194.00
194.01	07951	FOUNDATION	0	15,242	17,079	32,321	47	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	1,066,992	1,195,586	2,262,578	13,926	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet B Part II | Date/Time Prepared: 2/20/2013 1:52 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL 5.00	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	112,049					5.00
7.00	00700	OPERATION OF PLANT	6,905	382,491				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	600	8,732	49,616			8.00
9.00	00900	HOUSEKEEPING	2,375	4,928	2,231	32,570		9.00
10.00	01000	DIETARY	1,973	22,419	663	1,980	130,539	10.00
11.00	01100	CAFETERIA	1,153	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	827	1,479	0	131	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,055	7,141	0	631	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,255	43,831	16,707	3,871	45,925	30.00
31.00	03100	INTENSIVE CARE UNIT	1,904	10,371	239	916	0	31.00
44.00	04400	SKILLED NURSING FACILITY	8,230	51,086	15,202	4,509	84,614	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,198	27,342	3,471	2,414	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,092	18,728	2,240	1,654	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	660	2,250	0	199	0	54.03
60.00	06000	LABORATORY	6,786	8,196	0	724	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,247	8,636	1,088	763	0	65.00
66.00	06600	PHYSICAL THERAPY	4,078	15,059	3,508	1,330	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,460	4,382	0	387	0	67.00
68.00	06800	SPEECH PATHOLOGY	862	332	0	29	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,062	19,226	0	1,698	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,232	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,206	5,421	0	479	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,900	11,518	0	1,017	0	90.00
90.01	09001	DIABETES	390	7,489	0	661	0	90.01
90.02	09002	OP PSYCH	330	1,077	0	95	0	90.02
91.00	09100	EMERGENCY	7,040	47,404	4,267	4,186	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	CARDIAC REHAB	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,720	2,705	0	239	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	81,540	329,752	49,616	27,913	130,539	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	29,425	45,727	0	4,038	0	194.00
194.01	07951	FOUNDATION	0	7,012	0	619	0	194.01
194.02	07952	ASC	1,084	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	112,049	382,491	49,616	32,570	130,539	202.00

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			11.00	13.00	16.00	24.00	25.00	
1.00		**GENERAL SERVICE COST CENTERS**						1.00
2.00	00100	NEW CAP REL COSTS-BLDG & FIXT						2.00
4.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						4.00
5.00	00400	EMPLOYEE BENEFITS						5.00
7.00	00500	ADMINISTRATIVE & GENERAL						7.00
8.00	00700	OPERATION OF PLANT						8.00
9.00	00800	LAUNDRY & LINEN SERVICE						9.00
10.00	00900	HOUSEKEEPING						10.00
11.00	01000	DIETARY						11.00
13.00	01100	CAFETERIA						13.00
16.00	01300	NURSING ADMINISTRATION						16.00
	01600	MEDICAL RECORDS & LIBRARY	1,361					
30.00		**INPATIENT ROUTINE SERVICE COST CENTERS**						
31.00	03000	ADULTS & PEDIATRICS	9	9,405				
44.00	03100	INTENSIVE CARE UNIT	67	0	43,033			
	04400	SKILLED NURSING FACILITY	230					
50.00		**ANCILLARY SERVICE COST CENTERS**						
54.00	05000	OPERATING ROOM	48	3,155				
54.03	05400	RADIOLOGY-DIAGNOSTIC	270	658	12,214	337,321	0	30.00
60.00	05401	NUCLEAR MEDICINE-DIAGNOSTIC		3,735	658	62,904	0	31.00
65.00	06000	LABORATORY	64		188	404,397	0	44.00
66.00	06500	RESPIRATORY THERAPY	111	0				
67.00	06600	PHYSICAL THERAPY	0	0	4,698	169,779	0	50.00
68.00	06700	OCCUPATIONAL THERAPY	127	0	4,416	120,195	0	54.00
69.00	06800	SPEECH PATHOLOGY	56	0	0	13,480	0	54.03
71.00	06900	ELECTROCARDIOLOGY	110	0	5,168	59,426	0	60.00
72.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	34	0	1,597	55,527	0	65.00
73.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16	0	3,007	97,140	0	66.00
	07300	DRUGS CHARGED TO PATIENTS	0	0	0	26,697	0	67.00
90.00		**OUTPATIENT SERVICE COST CENTERS**	9	0	0	2,902	0	68.00
90.01	09000	CLINIC	0	0	0	0	0	69.00
90.02	09001	DIABETES	26	0	0	110,614	0	71.00
91.00	09002	OP PSYCH		0	0	2,232	0	72.00
92.00	09100	EMERGENCY	9			35,365	0	73.00
93.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	11	0				
	04040	CARDIAC REHAB	32	154	188	67,881	0	90.00
101.00		**OTHER REIMBURSABLE COST CENTERS**	124	0	0	43,260	0	90.01
	10100	HOME HEALTH AGENCY		1,703	0	6,548	0	90.02
113.00		**SPECIAL PURPOSE COST CENTERS**	0		10,711	294,665	0	91.00
118.00	11300	INTEREST EXPENSE		0			0	92.00
		SUBTOTALS (SUM OF LINES 1-117)	0		0	0	0	93.00
194.00		**NONREIMBURSABLE COST CENTERS**		0				
194.01	07950	MOB			94	17,461	0	101.00
194.02	07951	FOUNDATION	1,353					
200.00	07952	ASC		9,405				
201.00		Cross Foot Adjustments	0		42,939	1,927,794		113.00
202.00		Negative Cost Centers	8	0	94		0	118.00
		TOTAL (sum lines 118-201)	0	0	0	293,693		
				0	0	40,007	0	194.00
			1,361			1,084	0	194.01
				9,405	0	0	0	194.02
					43,033	0	0	200.00
						2,262,578	0	201.00
							0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet B Part II | Date/Time Prepared: 2/20/2013 1:52 pm

		Cost Center Description	Total 26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	337,321		30.00
31.00	03100	INTENSIVE CARE UNIT	62,904		31.00
44.00	04400	SKILLED NURSING FACILITY	404,397		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	169,779		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	120,195		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	13,480		54.03
60.00	06000	LABORATORY	59,426		60.00
65.00	06500	RESPIRATORY THERAPY	55,527		65.00
66.00	06600	PHYSICAL THERAPY	97,140		66.00
67.00	06700	OCCUPATIONAL THERAPY	26,697		67.00
68.00	06800	SPEECH PATHOLOGY	2,902		68.00
69.00	06900	ELECTROCARDIOLOGY	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	110,614		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,232		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	35,365		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	67,881		90.00
90.01	09001	DIABETES	43,260		90.01
90.02	09002	OP PSYCH	6,548		90.02
91.00	09100	EMERGENCY	294,665		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
93.00	04040	CARDIAC REHAB	0		93.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	17,461		101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,927,794		118.00
		NONREIMBURSABLE COST CENTERS			
194.00	07950	MOB	293,693		194.00
194.01	07951	FOUNDATION	40,007		194.01
194.02	07952	ASC	1,084		194.02
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	2,262,578		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet B-1 | Date/Time Prepared: 2/20/2013 1:52 pm

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET) 1.00	NEW MVBLE EQUIP (SQUARE FEET) 2.00	EMPLOYEE BENEFITS (GROSS SALARIES) 4.00	Reconciliation 5A	ADMINISTRATIVE & GENERAL (ACCUM. COST) 5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	91,633					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		91,633				2.00
4.00	00400	EMPLOYEE BENEFITS	564	564	14,003,542			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,469	4,469	1,712,314	-5,178,357	24,917,637	5.00
7.00	00700	OPERATION OF PLANT	15,200	15,200	274,588	0	1,535,388	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,630	1,630	36,222	0	133,492	8.00
9.00	00900	HOUSEKEEPING	920	920	320,715	0	528,104	9.00
10.00	01000	DIETARY	4,185	4,185	170,096	0	438,686	10.00
11.00	01100	CAFETERIA	0	0	208,781	0	256,392	11.00
13.00	01300	NURSING ADMINISTRATION	276	276	144,772	0	183,972	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,333	1,333	225,867	0	456,966	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,182	8,182	1,111,989	0	1,835,630	30.00
31.00	03100	INTENSIVE CARE UNIT	1,936	1,936	309,125	0	423,404	31.00
44.00	04400	SKILLED NURSING FACILITY	9,536	9,536	1,109,683	0	1,830,015	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,104	5,104	568,678	0	1,155,864	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,496	3,496	635,561	0	1,354,574	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	420	420	0	0	146,701	54.03
60.00	06000	LABORATORY	1,530	1,530	650,030	0	1,509,086	60.00
65.00	06500	RESPIRATORY THERAPY	1,612	1,612	338,984	0	722,008	65.00
66.00	06600	PHYSICAL THERAPY	2,811	2,811	642,589	0	906,900	66.00
67.00	06700	OCCUPATIONAL THERAPY	818	818	237,585	0	324,664	67.00
68.00	06800	SPEECH PATHOLOGY	62	62	133,145	0	191,701	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,589	3,589	0	0	236,236	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	496,258	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,012	1,012	246,976	0	935,337	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,150	2,150	162,993	0	422,593	90.00
90.01	09001	DIABETES	1,398	1,398	35,768	0	86,743	90.01
90.02	09002	OP PSYCH	201	201	51,623	0	73,421	90.02
91.00	09100	EMERGENCY	8,849	8,849	737,673	0	1,565,542	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	CARDIAC REHAB	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	505	505	235,562	0	382,412	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	81,788	81,788	10,301,319	-5,178,357	18,132,089	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	8,536	8,536	3,655,416	0	6,544,469	194.00
194.01	07951	FOUNDATION	1,309	1,309	46,807	4,223	0	194.01
194.02	07952	ASC	0	0	0	0	241,079	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,066,992	1,195,586	612,394		5,178,357	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.644189	13.047548	0.043731		0.207819	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			13,926		112,049	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000994		0.004497	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet B-1 | Date/Time Prepared: 2/20/2013 1:52 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET) 7.00	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY) 8.00	HOUSEKEEPING (SQUARE FEET) 9.00	DIETARY (MEALS SERVED) 10.00	CAFETERIA (FTE'S) 11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	71,400					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,630	565,804				8.00
9.00	00900	HOUSEKEEPING	920	25,438	68,850			9.00
10.00	01000	DIETARY	4,185	7,565	4,185	59,268		10.00
11.00	01100	CAFETERIA	0	0	0	0	316,629	11.00
13.00	01300	NURSING ADMINISTRATION	276	0	276	0	2,081	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,333	0	1,333	0	15,517	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,182	190,510	8,182	20,851	53,399	30.00
31.00	03100	INTENSIVE CARE UNIT	1,936	2,721	1,936	0	11,140	31.00
44.00	04400	SKILLED NURSING FACILITY	9,536	173,362	9,536	38,417	63,210	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,104	39,584	5,104	0	14,848	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,496	25,549	3,496	0	25,730	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	420	0	420	0	0	54.03
60.00	06000	LABORATORY	1,530	0	1,530	0	29,436	60.00
65.00	06500	RESPIRATORY THERAPY	1,612	12,412	1,612	0	13,020	65.00
66.00	06600	PHYSICAL THERAPY	2,811	40,006	2,811	0	25,635	66.00
67.00	06700	OCCUPATIONAL THERAPY	818	0	818	0	7,930	67.00
68.00	06800	SPEECH PATHOLOGY	62	0	62	0	3,666	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,589	0	3,589	0	2,103	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,012	0	1,012	0	6,165	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,150	0	2,150	0	2,086	90.00
90.01	09001	DIABETES	1,398	0	1,398	0	2,599	90.01
90.02	09002	OP PSYCH	201	0	201	0	7,425	90.02
91.00	09100	EMERGENCY	8,849	48,657	8,849	0	28,827	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	CARDIAC REHAB	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	505	0	505	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	61,555	565,804	59,005	59,268	314,817	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	MOB	8,536	0	8,536	0	0	194.00
194.01	07951	FOUNDATION	1,309	0	1,309	0	1,812	194.01
194.02	07952	ASC	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,854,471	203,570	670,901	682,052	309,675	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	25.972983	0.359789	9.744386	11.507930	0.978037	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	382,491	49,616	32,570	130,539	1,361	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.357017	0.087691	0.473057	2.202521	0.004298	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet B-1 | Date/Time Prepared: 2/20/2013 1:52 pm

		Cost Center Description	NURSING ADMINISTRATION (NRSE FTE'S)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			13.00	16.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION	159,175		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	458	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	53,399	130	30.00
31.00	03100	INTENSIVE CARE UNIT	11,140	7	31.00
44.00	04400	SKILLED NURSING FACILITY	63,210	2	44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	50	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	47	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	54.03
60.00	06000	LABORATORY	0	55	60.00
65.00	06500	RESPIRATORY THERAPY	0	17	65.00
66.00	06600	PHYSICAL THERAPY	0	32	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	2	90.00
90.01	09001	DIABETES	2,599	0	90.01
90.02	09002	OP PSYCH	0	0	90.02
91.00	09100	EMERGENCY	28,827	114	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
93.00	04040	CARDIAC REHAB	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0	1	101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	159,175	457	118.00
		NONREIMBURSABLE COST CENTERS			
194.00	07950	MOB	0	1	194.00
194.01	07951	FOUNDATION	0	0	194.01
194.02	07952	ASC	0	0	194.02
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	234,098	614,719	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.470696	1,342.181223	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	9,405	43,033	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.059086	93.958515	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet C Part I Date/Time Prepared: 2/20/2013 1:52 pm

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Title XVIII Therapy Limit Adj.	Title XVIII Total Costs	Hospital Costs RCE Disallowance	Cost Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,123,088		3,123,088	0	3,123,088	30.00
31.00	03100	INTENSIVE CARE UNIT	618,197		618,197	0	618,197	31.00
44.00	04400	SKILLED NURSING FACILITY	3,212,871		3,212,871	0	3,212,871	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,674,249		1,674,249	0	1,674,249	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,858,388		1,858,388	0	1,858,388	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	192,190		192,190	0	192,190	54.03
60.00	06000	LABORATORY	1,979,960		1,979,960	0	1,979,960	60.00
65.00	06500	RESPIRATORY THERAPY	969,648	0	969,648	0	969,648	65.00
66.00	06600	PHYSICAL THERAPY	1,278,188	0	1,278,188	0	1,278,188	66.00
67.00	06700	OCCUPATIONAL THERAPY	429,108	0	429,108	0	429,108	67.00
68.00	06800	SPEECH PATHOLOGY	237,339	0	237,339	0	237,339	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	415,577		415,577	0	415,577	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	599,390		599,390	0	599,390	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,171,894		1,171,894	0	1,171,894	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	591,932		591,932	0	591,932	90.00
90.01	09001	DIABETES	161,067		161,067	0	161,067	90.01
90.02	09002	OP PSYCH	103,121		103,121	0	103,121	90.02
91.00	09100	EMERGENCY	2,448,059		2,448,059	0	2,448,059	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	534,821		534,821		534,821	92.00
93.00	04040	CARDIAC REHAB	0		0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	481,263		481,263		481,263	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	22,080,350	0	22,080,350	0	22,080,350	200.00
201.00		Less Observation Beds	534,821		534,821		534,821	201.00
202.00		Total (see instructions)	21,545,529	0	21,545,529	0	21,545,529	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet C Part I Date/Time Prepared: 2/20/2013 1:52 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,960,077		1,960,077			30.00
31.00	03100	INTENSIVE CARE UNIT	425,728		425,728			31.00
44.00	04400	SKILLED NURSING FACILITY	1,969,455		1,969,455			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	797,706	3,760,274	4,557,980	0.367323	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	280,062	9,226,157	9,506,219	0.195492	0.000000	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	28,289	319,523	347,812	0.552569	0.000000	54.03
60.00	06000	LABORATORY	950,929	6,484,692	7,435,621	0.266280	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	689,105	1,827,659	2,516,764	0.385276	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,060,355	3,029,370	4,089,725	0.312536	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	455,661	1,212,446	1,668,107	0.257242	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	59,529	583,612	643,141	0.369031	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	861,648	519,556	1,381,204	0.300880	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	895,804	122,227	1,018,031	0.588774	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,028,553	1,800,882	2,829,435	0.414180	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	310,209	310,209	1.908172	0.000000	90.00
90.01	09001	DIABETES	0	29,812	29,812	5.402757	0.000000	90.01
90.02	09002	OP PSYCH	0	162,124	162,124	0.636063	0.000000	90.02
91.00	09100	EMERGENCY	125,643	6,574,004	6,699,647	0.365401	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	11,375	370,925	382,300	1.398956	0.000000	92.00
93.00	04040	CARDIAC REHAB	0	0	0	0.000000	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	508,131	508,131			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	11,599,919	36,841,603	48,441,522			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	11,599,919	36,841,603	48,441,522			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet C Part I Date/Time Prepared: 2/20/2013 1:52 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio 11.00			
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
44.00	04400	SKILLED NURSING FACILITY				44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.000000			50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.000000			54.03
60.00	06000	LABORATORY	0.000000			60.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000			90.00
90.01	09001	DIABETES	0.000000			90.01
90.02	09002	OP PSYCH	0.000000			90.02
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
93.00	04040	CARDIAC REHAB	0.000000			93.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY				101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet C Part I Date/Time Prepared: 2/20/2013 1:52 pm

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Title XIX Therapy Limit Adj.	Title XIX Total Costs	Hospital Costs RCE Disallowance	PPS Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,123,088		3,123,088	0	3,123,088	30.00
31.00	03100	INTENSIVE CARE UNIT	618,197		618,197	0	618,197	31.00
44.00	04400	SKILLED NURSING FACILITY	3,212,871		3,212,871	0	3,212,871	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,674,249		1,674,249	0	1,674,249	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,858,388		1,858,388	0	1,858,388	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	192,190		192,190	0	192,190	54.03
60.00	06000	LABORATORY	1,979,960		1,979,960	0	1,979,960	60.00
65.00	06500	RESPIRATORY THERAPY	969,648	0	969,648	0	969,648	65.00
66.00	06600	PHYSICAL THERAPY	1,278,188	0	1,278,188	0	1,278,188	66.00
67.00	06700	OCCUPATIONAL THERAPY	429,108	0	429,108	0	429,108	67.00
68.00	06800	SPEECH PATHOLOGY	237,339	0	237,339	0	237,339	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	415,577		415,577	0	415,577	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	599,390		599,390	0	599,390	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,171,894		1,171,894	0	1,171,894	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	591,932		591,932	0	591,932	90.00
90.01	09001	DIABETES	161,067		161,067	0	161,067	90.01
90.02	09002	OP PSYCH	103,121		103,121	0	103,121	90.02
91.00	09100	EMERGENCY	2,448,059		2,448,059	0	2,448,059	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	534,821		534,821		534,821	92.00
93.00	04040	CARDIAC REHAB	0		0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	481,263		481,263		481,263	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	22,080,350	0	22,080,350	0	22,080,350	200.00
201.00		Less Observation Beds	534,821		534,821		534,821	201.00
202.00		Total (see instructions)	21,545,529	0	21,545,529	0	21,545,529	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet C Part I Date/Time Prepared: 2/20/2013 1:52 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,960,077		1,960,077			30.00
31.00	03100	INTENSIVE CARE UNIT	425,728		425,728			31.00
44.00	04400	SKILLED NURSING FACILITY	1,969,455		1,969,455			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	797,706	3,760,274	4,557,980	0.367323	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	280,062	9,226,157	9,506,219	0.195492	0.000000	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	28,289	319,523	347,812	0.552569	0.000000	54.03
60.00	06000	LABORATORY	950,929	6,484,692	7,435,621	0.266280	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	689,105	1,827,659	2,516,764	0.385276	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,060,355	3,029,370	4,089,725	0.312536	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	455,661	1,212,446	1,668,107	0.257242	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	59,529	583,612	643,141	0.369031	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	861,648	519,556	1,381,204	0.300880	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	895,804	122,227	1,018,031	0.588774	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,028,553	1,800,882	2,829,435	0.414180	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	310,209	310,209	1.908172	0.000000	90.00
90.01	09001	DIABETES	0	29,812	29,812	5.402757	0.000000	90.01
90.02	09002	OP PSYCH	0	162,124	162,124	0.636063	0.000000	90.02
91.00	09100	EMERGENCY	125,643	6,574,004	6,699,647	0.365401	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	11,375	370,925	382,300	1.398956	0.000000	92.00
93.00	04040	CARDIAC REHAB	0	0	0	0.000000	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	508,131	508,131			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	11,599,919	36,841,603	48,441,522			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	11,599,919	36,841,603	48,441,522			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet C Part I Date/Time Prepared: 2/20/2013 1:52 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio 11.00			
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
44.00	04400	SKILLED NURSING FACILITY				44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.367323			50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.195492			54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.552569			54.03
60.00	06000	LABORATORY	0.266280			60.00
65.00	06500	RESPIRATORY THERAPY	0.385276			65.00
66.00	06600	PHYSICAL THERAPY	0.312536			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.257242			67.00
68.00	06800	SPEECH PATHOLOGY	0.369031			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.300880			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.588774			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.414180			73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.908172			90.00
90.01	09001	DIABETES	5.402757			90.01
90.02	09002	OP PSYCH	0.636063			90.02
91.00	09100	EMERGENCY	0.365401			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.398956			92.00
93.00	04040	CARDIAC REHAB	0.000000			93.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY				101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet C Part II | Date/Time Prepared: 2/20/2013 1:52 pm

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Title XIX Capital Cost (Wkst. B, Part II col. 26)	Title XIX Operating Cost Net of Capital Cost (col. 1 - col. 2)	Hospital Capital Reduction	PPS Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,674,249	169,779	1,504,470	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,858,388	120,195	1,738,193	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	192,190	13,480	178,710	0	0	54.03
60.00	06000	LABORATORY	1,979,960	59,426	1,920,534	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	969,648	55,527	914,121	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,278,188	97,140	1,181,048	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	429,108	26,697	402,411	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	237,339	2,902	234,437	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	415,577	110,614	304,963	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	599,390	2,232	597,158	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,171,894	35,365	1,136,529	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	591,932	67,881	524,051	0	0	90.00
90.01	09001	DIABETES	161,067	43,260	117,807	0	0	90.01
90.02	09002	OP PSYCH	103,121	6,548	96,573	0	0	90.02
91.00	09100	EMERGENCY	2,448,059	294,665	2,153,394	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	534,821	0	534,821	0	0	92.00
93.00	04040	CARDIAC REHAB	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	481,263	17,461	463,802	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	15,126,194	1,123,172	14,003,022	0	0	200.00
201.00		Less Observation Beds	534,821	0	534,821	0	0	201.00
202.00		Total (line 200 minus line 201)	14,591,373	1,123,172	13,468,201	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet C Part II | Date/Time Prepared: 2/20/2013 1:52 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)			
			6.00	7.00	8.00			
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,674,249	4,557,980	0.367323			50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,858,388	9,506,219	0.195492			54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	192,190	347,812	0.552569			54.03
60.00	06000	LABORATORY	1,979,960	7,435,621	0.266280			60.00
65.00	06500	RESPIRATORY THERAPY	969,648	2,516,764	0.385276			65.00
66.00	06600	PHYSICAL THERAPY	1,278,188	4,089,725	0.312536			66.00
67.00	06700	OCCUPATIONAL THERAPY	429,108	1,668,107	0.257242			67.00
68.00	06800	SPEECH PATHOLOGY	237,339	643,141	0.369031			68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	415,577	1,381,204	0.300880			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	599,390	1,018,031	0.588774			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,171,894	2,829,435	0.414180			73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	591,932	310,209	1.908172			90.00
90.01	09001	DIABETES	161,067	29,812	5.402757			90.01
90.02	09002	OP PSYCH	103,121	162,124	0.636063			90.02
91.00	09100	EMERGENCY	2,448,059	6,699,647	0.365401			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	534,821	382,300	1.398956			92.00
93.00	04040	CARDIAC REHAB	0	0	0.000000			93.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	481,263	508,131	0.947124			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	15,126,194	44,086,262				200.00
201.00		Less Observation Beds	534,821	0				201.00
202.00		Total (line 200 minus line 201)	14,591,373	44,086,262				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D Part II | Date/Time Prepared: 2/20/2013 1:52 pm

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Title XVIII Total Charges (from Wkst. C, Part I, col. 8)	Title XVIII Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital Inpatient Program Charges	Cost Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	169,779	4,557,980	0.037249	508,881	18,955	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	120,195	9,506,219	0.012644	148,749	1,881	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	13,480	347,812	0.038757	16,306	632	54.03
60.00	06000	LABORATORY	59,426	7,435,621	0.007992	507,310	4,054	60.00
65.00	06500	RESPIRATORY THERAPY	55,527	2,516,764	0.022063	266,076	5,870	65.00
66.00	06600	PHYSICAL THERAPY	97,140	4,089,725	0.023752	162,138	3,851	66.00
67.00	06700	OCCUPATIONAL THERAPY	26,697	1,668,107	0.016004	53,779	861	67.00
68.00	06800	SPEECH PATHOLOGY	2,902	643,141	0.004512	11,912	54	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	110,614	1,381,204	0.080085	227,223	18,197	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,232	1,018,031	0.002192	867,914	1,902	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	35,365	2,829,435	0.012499	422,198	5,277	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	67,881	310,209	0.218823	0	0	90.00
90.01	09001	DIABETES	43,260	29,812	1.451094	0	0	90.01
90.02	09002	OP PSYCH	6,548	162,124	0.040389	0	0	90.02
91.00	09100	EMERGENCY	294,665	6,699,647	0.043982	4,182	184	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	382,300	0.000000	3,164	0	92.00
93.00	04040	CARDIAC REHAB	0	0	0.000000	0	0	93.00
200.00		Total (lines 50-199)	1,105,711	43,578,131		3,199,832	61,718	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D Part IV | Date/Time Prepared: 2/20/2013 1:52 pm

		Cost Center Description	Title XVIII Non Physician Anesthetist Cost	Title XVIII Nursing School	Title XVIII Allied Health	Hospital All Other Medical Education Cost	Cost Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	0	54.03
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DIABETES	0	0	0	0	0	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	CARDIAC REHAB	0	0	0	0	0	93.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D Part IV | Date/Time Prepared: 2/20/2013 1:52 pm

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Title XVIII Total Charges (from Wkst. C, Part I, col. 8)	Title XVIII Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Cost Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,557,980	0.000000	0.000000	508,881	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,506,219	0.000000	0.000000	148,749	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	347,812	0.000000	0.000000	16,306	54.03
60.00	06000	LABORATORY	0	7,435,621	0.000000	0.000000	507,310	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,516,764	0.000000	0.000000	266,076	65.00
66.00	06600	PHYSICAL THERAPY	0	4,089,725	0.000000	0.000000	162,138	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,668,107	0.000000	0.000000	53,779	67.00
68.00	06800	SPEECH PATHOLOGY	0	643,141	0.000000	0.000000	11,912	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,381,204	0.000000	0.000000	227,223	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,018,031	0.000000	0.000000	867,914	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,829,435	0.000000	0.000000	422,198	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	310,209	0.000000	0.000000	0	90.00
90.01	09001	DIABETES	0	29,812	0.000000	0.000000	0	90.01
90.02	09002	OP PSYCH	0	162,124	0.000000	0.000000	0	90.02
91.00	09100	EMERGENCY	0	6,699,647	0.000000	0.000000	4,182	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	382,300	0.000000	0.000000	3,164	92.00
93.00	04040	CARDIAC REHAB	0	0	0.000000	0.000000	0	93.00
200.00		Total (lines 50-199)	0	43,578,131			3,199,832	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D Part IV | Date/Time Prepared: 2/20/2013 1:52 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10) 11.00	Outpatient Program Charges 12.00	Outpatient Program Pass-Through Costs (col. 9 x col. 12) 13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0		54.03
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	DIABETES	0	0	0		90.01
90.02	09002	OP PSYCH	0	0	0		90.02
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	04040	CARDIAC REHAB	0	0	0		93.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D Part V Date/Time Prepared: 2/20/2013 1:52 pm

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Title XVIII PPS Reimbursed Services (see inst.)	Charges Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Hospital Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Cost	
			1.00	2.00	3.00	4.00		
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.367323	0	1,151,617	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.195492	0	2,515,855	0		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.552569	0	109,303	0		54.03
60.00	06000	LABORATORY	0.266280	0	2,019,861	0		60.00
65.00	06500	RESPIRATORY THERAPY	0.385276	0	505,304	0		65.00
66.00	06600	PHYSICAL THERAPY	0.312536	0	1,103,101	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.257242	0	243,084	0		67.00
68.00	06800	SPEECH PATHOLOGY	0.369031	0	72,723	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.300880	0	83,353	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.588774	0	108,514	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.414180	0	724,160	1,997		73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.908172	0	300,078	0		90.00
90.01	09001	DIABETES	5.402757	0	6,335	0		90.01
90.02	09002	OP PSYCH	0.636063	0	0	0		90.02
91.00	09100	EMERGENCY	0.365401	0	1,297,563	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.398956	0	156,428	0		92.00
93.00	04040	CARDIAC REHAB	0.000000	0	0	0		93.00
200.00		Subtotal (see instructions)		0	10,397,279	1,997		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	10,397,279	1,997		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D Part V Date/Time Prepared: 2/20/2013 1:52 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Services (see inst.)	Costs Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
			5.00	6.00	7.00			
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	423,015	0			50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	491,830	0			54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	60,397	0			54.03
60.00	06000	LABORATORY	0	537,849	0			60.00
65.00	06500	RESPIRATORY THERAPY	0	194,682	0			65.00
66.00	06600	PHYSICAL THERAPY	0	344,759	0			66.00
67.00	06700	OCCUPATIONAL THERAPY	0	62,531	0			67.00
68.00	06800	SPEECH PATHOLOGY	0	26,837	0			68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	25,079	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	63,890	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	299,933	827			73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	572,600	0			90.00
90.01	09001	DIABETES	0	34,226	0			90.01
90.02	09002	OP PSYCH	0	0	0			90.02
91.00	09100	EMERGENCY	0	474,131	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	218,836	0			92.00
93.00	04040	CARDIAC REHAB	0	0	0			93.00
200.00		Subtotal (see instructions)	0	3,830,595	827			200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0				201.00
202.00		Net Charges (line 200 +/- line 201)	0	3,830,595	827			202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151319 | Component CCN: 15Z319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D Part V | Date/Time Prepared: 2/20/2013 1:52 pm

Title XVIII | Swing Beds - SNF

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see inst.)	Charges Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Cost	
			1.00	2.00	3.00	4.00		
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.367323	0	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.195492	0	0	0		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.552569	0	0	0		54.03
60.00	06000	LABORATORY	0.266280	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0.385276	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0.312536	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.257242	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0.369031	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.300880	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.588774	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.414180	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.908172	0	0	0		90.00
90.01	09001	DIABETES	5.402757	0	0	0		90.01
90.02	09002	OP PSYCH	0.636063	0	0	0		90.02
91.00	09100	EMERGENCY	0.365401	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.398956	0	0	0		92.00
93.00	04040	CARDIAC REHAB	0.000000	0	0	0		93.00
200.00		Subtotal (see instructions)		0	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D Part V

Component CCN: 15Z319 | Date/Time Prepared: 2/20/2013 1:52 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	PPS Services (see inst.)	Costs Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
			5.00	6.00	7.00			
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0			50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0			54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0			54.03
60.00	06000	LABORATORY	0	0	0			60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0			65.00
66.00	06600	PHYSICAL THERAPY	0	0	0			66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0			67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0			68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0			73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0			90.00
90.01	09001	DIABETES	0	0	0			90.01
90.02	09002	OP PSYCH	0	0	0			90.02
91.00	09100	EMERGENCY	0	0	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0			92.00
93.00	04040	CARDIAC REHAB	0	0	0			93.00
200.00		Subtotal (see instructions)	0	0	0			200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0				201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	0			202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151319
Component CCN: 155093
Period: From 10/01/2011 To 09/30/2012
Worksheet D Part IV
Date/Time Prepared: 2/20/2013 1:52 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	0	54.03
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DIABETES	0	0	0	0	0	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	CARDIAC REHAB	0	0	0	0	0	93.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151319
Component CCN: 155093

Period: From 10/01/2011 To 09/30/2012

Worksheet D
Part IV
Date/Time Prepared: 2/20/2013 1:52 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,557,980	0.000000	0.000000	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,506,219	0.000000	0.000000	21,191	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	347,812	0.000000	0.000000	0	54.03
60.00	06000	LABORATORY	0	7,435,621	0.000000	0.000000	124,175	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,516,764	0.000000	0.000000	55,349	65.00
66.00	06600	PHYSICAL THERAPY	0	4,089,725	0.000000	0.000000	492,408	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,668,107	0.000000	0.000000	256,545	67.00
68.00	06800	SPEECH PATHOLOGY	0	643,141	0.000000	0.000000	23,712	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,381,204	0.000000	0.000000	20,584	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,018,031	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,829,435	0.000000	0.000000	211,980	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	310,209	0.000000	0.000000	0	90.00
90.01	09001	DIABETES	0	29,812	0.000000	0.000000	0	90.01
90.02	09002	OP PSYCH	0	162,124	0.000000	0.000000	0	90.02
91.00	09100	EMERGENCY	0	6,699,647	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	382,300	0.000000	0.000000	0	92.00
93.00	04040	CARDIAC REHAB	0	0	0.000000	0.000000	0	93.00
200.00		Total (lines 50-199)	0	43,578,131			1,205,944	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151319 | Component CCN: 155093 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D Part IV | Date/Time Prepared: 2/20/2013 1:52 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0		54.03
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	DIABETES	0	0	0		90.01
90.02	09002	OP PSYCH	0	0	0		90.02
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	04040	CARDIAC REHAB	0	0	0		93.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D Part I | Date/Time Prepared: 2/20/2013 1:52 pm

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Title XIX Swing Bed Adjustment	Title XIX Reduced Capital Related Cost (col. 1 - col. 2)	Hospital Total Patient Days	PPS Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	337,321	77,593	259,728	2,410	107.77	30.00
31.00	03100	INTENSIVE CARE UNIT	62,904		62,904	408	154.18	31.00
44.00	04400	SKILLED NURSING FACILITY	404,397		404,397	12,172	33.22	44.00
200.00		Total (lines 30-199)	804,622		727,029	14,990		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D Part I Date/Time Prepared: 2/20/2013 1:52 pm

Title XIX | Hospital | PPS

		Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)			
			6.00	7.00			
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	74	7,975			30.00
31.00	03100	INTENSIVE CARE UNIT	0	0			31.00
44.00	04400	SKILLED NURSING FACILITY	0	0			44.00
200.00		Total (lines 30-199)	74	7,975			200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D Part II Date/Time Prepared: 2/20/2013 1:52 pm

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Title XIX Total Charges (from Wkst. C, Part I, col. 8)	Title XIX Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital Inpatient Program Charges	PPS Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	169,779	4,557,980	0.037249	71,714	2,671	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	120,195	9,506,219	0.012644	13,989	177	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	13,480	347,812	0.038757	998	39	54.03
60.00	06000	LABORATORY	59,426	7,435,621	0.007992	40,809	326	60.00
65.00	06500	RESPIRATORY THERAPY	55,527	2,516,764	0.022063	53,591	1,182	65.00
66.00	06600	PHYSICAL THERAPY	97,140	4,089,725	0.023752	9,338	222	66.00
67.00	06700	OCCUPATIONAL THERAPY	26,697	1,668,107	0.016004	3,768	60	67.00
68.00	06800	SPEECH PATHOLOGY	2,902	643,141	0.004512	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	110,614	1,381,204	0.080085	233	19	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,232	1,018,031	0.002192	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	35,365	2,829,435	0.012499	38,065	476	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	67,881	310,209	0.218823	0	0	90.00
90.01	09001	DIABETES	43,260	29,812	1.451094	0	0	90.01
90.02	09002	OP PSYCH	6,548	162,124	0.040389	0	0	90.02
91.00	09100	EMERGENCY	294,665	6,699,647	0.043982	13,336	587	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	75,023	382,300	0.196241	0	0	92.00
93.00	04040	CARDIAC REHAB	0	0	0.000000	0	0	93.00
200.00		Total (lines 50-199)	1,180,734	43,578,131		245,841	5,759	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D Part III Date/Time Prepared: 2/20/2013 1:52 pm

		Cost Center Description	Nursing School	Title XIX Allied Health Cost	Title XIX All Other Medical Education Cost	Hospital Swing-Bed Adjustment Amount (see instructions)	PPS Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		0	44.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D Part III Date/Time Prepared: 2/20/2013 1:52 pm

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Title XIX Inpatient Program Days	Hospital Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PPS	
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,410	0.00	74	0		30.00
31.00	03100	INTENSIVE CARE UNIT	408	0.00	0	0		31.00
44.00	04400	SKILLED NURSING FACILITY	12,172	0.00	0	0		44.00
200.00		Total (lines 30-199)	14,990		74	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D Part IV | Date/Time Prepared: 2/20/2013 1:52 pm

		Cost Center Description	Title XIX Non Physician Anesthetist Cost	Title XIX Nursing School	Title XIX Allied Health	Hospital All Other Medical Education Cost	PPS Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	0	54.03
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DIABETES	0	0	0	0	0	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	CARDIAC REHAB	0	0	0	0	0	93.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D Part IV | Date/Time Prepared: 2/20/2013 1:52 pm

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Title XIX Total Charges (from Wkst. C, Part I, col. 8)	Title XIX Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,557,980	0.000000	0.000000	71,714	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,506,219	0.000000	0.000000	13,989	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	347,812	0.000000	0.000000	998	54.03
60.00	06000	LABORATORY	0	7,435,621	0.000000	0.000000	40,809	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,516,764	0.000000	0.000000	53,591	65.00
66.00	06600	PHYSICAL THERAPY	0	4,089,725	0.000000	0.000000	9,338	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,668,107	0.000000	0.000000	3,768	67.00
68.00	06800	SPEECH PATHOLOGY	0	643,141	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,381,204	0.000000	0.000000	233	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,018,031	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,829,435	0.000000	0.000000	38,065	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	310,209	0.000000	0.000000	0	90.00
90.01	09001	DIABETES	0	29,812	0.000000	0.000000	0	90.01
90.02	09002	OP PSYCH	0	162,124	0.000000	0.000000	0	90.02
91.00	09100	EMERGENCY	0	6,699,647	0.000000	0.000000	13,336	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	382,300	0.000000	0.000000	0	92.00
93.00	04040	CARDIAC REHAB	0	0	0.000000	0.000000	0	93.00
200.00		Total (lines 50-199)	0	43,578,131			245,841	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D Part IV | Date/Time Prepared: 2/20/2013 1:52 pm

Title XIX | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0		54.03
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	DIABETES	0	0	0		90.01
90.02	09002	OP PSYCH	0	0	0		90.02
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	04040	CARDIAC REHAB	0	0	0		93.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D Part V Date/Time Prepared: 2/20/2013 1:52 pm

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Title XIX Charges PPS Reimbursed Services (see inst.)	Title XIX Charges Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Hospital Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS	
			1.00	2.00	3.00	4.00		
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.367323	0	0	412,970		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.195492	0	0	1,216,117		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.552569	0	0	29,400		54.03
60.00	06000	LABORATORY	0.266280	0	0	800,264		60.00
65.00	06500	RESPIRATORY THERAPY	0.385276	0	0	131,064		65.00
66.00	06600	PHYSICAL THERAPY	0.312536	0	0	151,706		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.257242	0	0	90,956		67.00
68.00	06800	SPEECH PATHOLOGY	0.369031	0	0	167,150		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.300880	0	0	3		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.588774	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.414180	0	0	164,364		73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.908172	0	0	0		90.00
90.01	09001	DIABETES	5.402757	0	0	2,138		90.01
90.02	09002	OP PSYCH	0.636063	0	0	0		90.02
91.00	09100	EMERGENCY	0.365401	0	0	1,413,182		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.398956	0	0	0		92.00
93.00	04040	CARDIAC REHAB	0.000000	0	0	0		93.00
200.00		Subtotal (see instructions)		0	0	4,579,314		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	4,579,314		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D Part V Date/Time Prepared: 2/20/2013 1:52 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Services (see inst.)	Costs Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			5.00	6.00	7.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	151,693		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	237,741		54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	16,246		54.03
60.00	06000	LABORATORY	0	0	213,094		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	50,496		65.00
66.00	06600	PHYSICAL THERAPY	0	0	47,414		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	23,398		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	61,684		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	68,076		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	DIABETES	0	0	11,551		90.01
90.02	09002	OP PSYCH	0	0	0		90.02
91.00	09100	EMERGENCY	0	0	516,378		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	04040	CARDIAC REHAB	0	0	0		93.00
200.00		Subtotal (see instructions)	0	0	1,397,772		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	1,397,772		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D-1 | Date/Time Prepared: 2/20/2013 1:52 pm

Title XVIII | Hospital

	Cost Center Description	Cost	
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,229	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,410	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,874	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	524	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	174	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	91	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	30	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,258	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	524	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	174	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	181.25	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	181.25	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,123,088	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	16,494	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	5,438	25.00
26.00	Total swing-bed cost (see instructions)	718,396	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,404,692	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	2,323,551	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	2,323,551	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.034921	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	1,239.89	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,404,692	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	997.80	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,255,232	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,255,232	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D-1 | Date/Time Prepared: 2/20/2013 1:52 pm

	Cost Center Description	Total Inpatient Cost 1.00	Title XVIII Total Inpatient Days 2.00	Title XVIII Average Per Diem (col. 1 ÷ col. 2) 3.00	Hospital Program Days 4.00	Cost Program Cost (col. 3 x col. 4) 5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	618,197	408	1,515.19	188	284,856	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,291,709	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,831,797	49.00
	PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					522,847	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					173,617	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					696,464	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					536	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					997.80	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					534,821	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D-1 | Date/Time Prepared: 2/20/2013 1:52 pm

	Cost Center Description	Cost	Title XVIII Routine Cost (from line 27)	Title XVIII column 1 ÷ column 2	Hospital Total Observation Bed Cost (from line 89)	Cost Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D-1

Component CCN: 155093 | Date/Time Prepared: 2/20/2013 1:52 pm

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description		
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	12,172	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	12,172	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	12,172	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,937	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	181.25	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	181.25	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,212,871	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,212,871	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	1,972,579	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	1,972,579	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.628767	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	162.06	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,212,871	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D-1
Component CCN: 155093 | Date/Time Prepared: 2/20/2013 1:52 pm

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Total Inpatient Cost 1.00	Total Inpatient Days 2.00	Average Per Diem (col. 1 ÷ col. 2) 3.00	Program Days 4.00	Program Cost (col. 3 x col. 4) 5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description						
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						49.00
	PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges						54.00
55.00	Target amount per discharge						55.00
56.00	Target amount (line 54 x line 55)						56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00	Bonus payment (see instructions)						58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61.00
62.00	Relief payment (see instructions)						62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					3,212,871	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					263.96	71.00
72.00	Program routine service cost (line 9 x line 71)					511,291	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					511,291	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)					0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0	80.00
81.00	Inpatient routine service cost per diem limitation					0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)					511,291	83.00
84.00	Program inpatient ancillary services (see instructions)					381,163	84.00
85.00	Utilization review - physician compensation (see instructions)					0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					892,454	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151319 | Component CCN: 155093 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D-1 | Date/Time Prepared: 2/20/2013 1:52 pm

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D-1 | Date/Time Prepared: 2/20/2013 1:52 pm

	Cost Center Description	Title XIX	Hospital	PPS	
				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			3,229	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			2,410	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			1,874	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			524	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			174	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			121	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			74	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			121	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
	SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period				17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period				18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			181.25	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			181.25	20.00
21.00	Total general inpatient routine service cost (see instructions)			3,123,088	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			21,931	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0	25.00
26.00	Total swing-bed cost (see instructions)			718,395	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			2,404,693	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)			2,323,551	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			2,323,551	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			1.034922	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			1,239.89	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			2,404,693	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			997.80	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			73,837	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			73,837	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D-1 | Date/Time Prepared: 2/20/2013 1:52 pm

	Cost Center Description	Total Inpatient Cost 1.00	Title XIX Total Inpatient Days 2.00	Title XIX Average Per Diem (col. 1 ÷ col. 2) 3.00	Hospital Program Days 4.00	PPS Program Cost (col. 3 x col. 4) 5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	618,197	408	1,515.19	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					85,738	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					159,575	49.00
	PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					7,975	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					5,759	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					13,734	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					145,841	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					21,931	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					21,931	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					536	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					997.80	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					534,821	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D-1 | Date/Time Prepared: 2/20/2013 1:52 pm

	Cost Center Description	Cost	Title XIX Routine Cost (from line 27)	Title XIX column 1 ÷ column 2	Hospital Total Observation Bed Cost (from line 89)	PPS Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	337,321	2,404,693	0.140276	534,821	75,023	90.00
91.00	Nursing School cost	0	2,404,693	0.000000	534,821	0	91.00
92.00	Allied health cost	0	2,404,693	0.000000	534,821	0	92.00
93.00	All other Medical Education	0	2,404,693	0.000000	534,821	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D-1

Component CCN: 155093 | Date/Time Prepared: 2/20/2013 1:52 pm

	Cost Center Description	Title XIX	Skilled Nursing Facility	Cost	
				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			12,172	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			12,172	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			12,172	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
	SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period				17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period				18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			181.25	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			181.25	20.00
21.00	Total general inpatient routine service cost (see instructions)			3,212,871	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0	25.00
26.00	Total swing-bed cost (see instructions)			0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			3,212,871	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)			1,972,579	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			1,972,579	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			1.628767	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			162.06	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			3,212,871	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)				38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)				39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)				40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)				41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151319 | Component CCN: 155093 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D-1 | Date/Time Prepared: 2/20/2013 1:52 pm

Title XIX | Skilled Nursing Facility | Cost

	Cost Center Description	Total Inpatient Cost 1.00	Total Inpatient Days 2.00	Average Per Diem (col. 1 ÷ col. 2) 3.00	Program Days 4.00	Program Cost (col. 3 x col. 4) 5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						49.00
	PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges						54.00
55.00	Target amount per discharge						55.00
56.00	Target amount (line 54 x line 55)						56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00	Bonus payment (see instructions)						58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61.00
62.00	Relief payment (see instructions)						62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					3,212,871	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					263.96	71.00
72.00	Program routine service cost (line 9 x line 71)					0	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					0	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					404,397	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					33.22	76.00
77.00	Program capital-related costs (line 9 x line 76)					0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0	80.00
81.00	Inpatient routine service cost per diem limitation					0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)					0	83.00
84.00	Program inpatient ancillary services (see instructions)					0	84.00
85.00	Utilization review - physician compensation (see instructions)					0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					0	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151319 | Component CCN: 155093 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D-1 | Date/Time Prepared: 2/20/2013 1:52 pm

Title XIX | Skilled Nursing Facility | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D-3 | Date/Time Prepared: 2/20/2013 1:52 pm

		Cost Center Description	Title XVIII Ratio of Cost To Charges	Hospital Inpatient Program Charges	Cost Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		857,614		30.00
31.00	03100	INTENSIVE CARE UNIT		280,872		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.367323	508,881	186,924	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.195492	148,749	29,079	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.552569	16,306	9,010	54.03
60.00	06000	LABORATORY	0.266280	507,310	135,087	60.00
65.00	06500	RESPIRATORY THERAPY	0.385276	266,076	102,513	65.00
66.00	06600	PHYSICAL THERAPY	0.312536	162,138	50,674	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.257242	53,779	13,834	67.00
68.00	06800	SPEECH PATHOLOGY	0.369031	11,912	4,396	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.300880	227,223	68,367	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.588774	867,914	511,005	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.414180	422,198	174,866	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.908172	0	0	90.00
90.01	09001	DIABETES	5.402757	0	0	90.01
90.02	09002	OP PSYCH	0.636063	0	0	90.02
91.00	09100	EMERGENCY	0.365401	4,182	1,528	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.398956	3,164	4,426	92.00
93.00	04040	CARDIAC REHAB	0.000000	0	0	93.00
200.00		Total (sum of lines 50-94 and 96-98)		3,199,832	1,291,709	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		3,199,832		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D-3

Component CCN: 15Z319 | Date/Time Prepared: 2/20/2013 1:52 pm

		Cost Center Description	Title XVIII Ratio of Cost To Charges	Swing Beds - SNF Inpatient Program Charges	Cost Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.367323	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.195492	20,334	3,975	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.552569	0	0	54.03
60.00	06000	LABORATORY	0.266280	109,673	29,204	60.00
65.00	06500	RESPIRATORY THERAPY	0.385276	78,467	30,231	65.00
66.00	06600	PHYSICAL THERAPY	0.312536	185,217	57,887	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.257242	55,029	14,156	67.00
68.00	06800	SPEECH PATHOLOGY	0.369031	5,335	1,969	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.300880	68,567	20,630	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.588774	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.414180	147,120	60,934	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.908172	0	0	90.00
90.01	09001	DIABETES	5.402757	0	0	90.01
90.02	09002	OP PSYCH	0.636063	0	0	90.02
91.00	09100	EMERGENCY	0.365401	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.398956	0	0	92.00
93.00	04040	CARDIAC REHAB	0.000000	0	0	93.00
200.00		Total (sum of lines 50-94 and 96-98)		669,742	218,986	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		669,742		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151319 | Component CCN: 155093 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D-3 | Date/Time Prepared: 2/20/2013 1:52 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.367323	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.195492	21,191	4,143	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.552569	0	0	54.03
60.00	06000	LABORATORY	0.266280	124,175	33,065	60.00
65.00	06500	RESPIRATORY THERAPY	0.385276	55,349	21,325	65.00
66.00	06600	PHYSICAL THERAPY	0.312536	492,408	153,895	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.257242	256,545	65,994	67.00
68.00	06800	SPEECH PATHOLOGY	0.369031	23,712	8,750	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.300880	20,584	6,193	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.588774	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.414180	211,980	87,798	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.908172	0	0	90.00
90.01	09001	DIABETES	5.402757	0	0	90.01
90.02	09002	OP PSYCH	0.636063	0	0	90.02
91.00	09100	EMERGENCY	0.365401	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.398956	0	0	92.00
93.00	04040	CARDIAC REHAB	0.000000	0	0	93.00
200.00		Total (sum of lines 50-94 and 96-98)		1,205,944	381,163	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,205,944		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet D-3 | Date/Time Prepared: 2/20/2013 1:52 pm

		Cost Center Description	Title XIX Ratio of Cost To Charges	Hospital Inpatient Program Charges	PPS Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		91,627		30.00
31.00	03100	INTENSIVE CARE UNIT		18,645		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.367323	71,714	26,342	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.195492	13,989	2,735	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.552569	998	551	54.03
60.00	06000	LABORATORY	0.266280	40,809	10,867	60.00
65.00	06500	RESPIRATORY THERAPY	0.385276	53,591	20,647	65.00
66.00	06600	PHYSICAL THERAPY	0.312536	9,338	2,918	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.257242	3,768	969	67.00
68.00	06800	SPEECH PATHOLOGY	0.369031	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.300880	233	70	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.588774	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.414180	38,065	15,766	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.908172	0	0	90.00
90.01	09001	DIABETES	5.402757	0	0	90.01
90.02	09002	OP PSYCH	0.636063	0	0	90.02
91.00	09100	EMERGENCY	0.365401	13,336	4,873	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.398956	0	0	92.00
93.00	04040	CARDIAC REHAB	0.000000	0	0	93.00
200.00		Total (sum of lines 50-94 and 96-98)		245,841	85,738	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		245,841		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet E Part B Date/Time Prepared: 2/20/2013 1:52 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,831,422	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	3,831,422	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	3,869,736	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	46,064	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,665,349	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	2,158,323	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,158,323	30.00
31.00	Primary payer payments	577	31.00
32.00	Subtotal (line 30 minus line 31)	2,157,746	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Worksheet I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	148,782	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	148,782	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	2,306,528	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)	2,306,528	40.00
41.00	Interim payments	2,609,275	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)	-302,747	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet E-1 Part I | Date/Time Prepared: 2/20/2013 1:52 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy 1.00	Amount 2.00	mm/dd/yyyy 3.00	Amount 4.00	
1.00	Total interim payments paid to provider		2,276,548		2,239,814	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	04/26/2012	50,695	09/19/2012	369,500	3.01
3.02		09/19/2012	119,700		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0	04/26/2012	39	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		170,395		369,461	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,446,943		2,609,275	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		68,974		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		302,747	6.02
7.00	Total Medicare program liability (see instructions)		2,515,917		2,306,528	7.00
				Contractor Number 1.00	Date (Mo/Day/Yr) 2.00	
8.00	Name of Contractor		0			8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151319 | Component CCN: 15Z319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet E-1 Part I | Date/Time Prepared: 2/20/2013 1:52 pm

		Title XVIII Inpatient Part A		Swing Beds - SNF Part B		Cost	
		mm/dd/yyyy 1.00	Amount 2.00	mm/dd/yyyy 3.00	Amount 4.00		
1.00	Total interim payments paid to provider		861,638			0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
	Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	04/26/2012	13,447			0	3.01
3.02			0			0	3.02
3.03			0			0	3.03
3.04			0			0	3.04
3.05			0			0	3.05
	Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0			0	3.50
3.51			0			0	3.51
3.52			0			0	3.52
3.53			0			0	3.53
3.54			0			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		13,447			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		875,085			0	4.00
	TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
	Program to Provider						
5.01	TENTATIVE TO PROVIDER		0			0	5.01
5.02			0			0	5.02
5.03			0			0	5.03
	Provider to Program						
5.50	TENTATIVE TO PROGRAM		0			0	5.50
5.51			0			0	5.51
5.52			0			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0			0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		33,019			0	6.01
6.02	SETTLEMENT TO PROGRAM		0			0	6.02
7.00	Total Medicare program liability (see instructions)		908,104			0	7.00
				Contractor Number 1.00	Date (Mo/Day/Yr) 2.00		
8.00	Name of Contractor	0					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151319 | Component CCN: 155093 | Period: From 10/01/2011 To 09/30/2012 | Worksheet E-1 Part I | Date/Time Prepared: 2/20/2013 1:52 pm

Title XVIII | Skilled Nursing Facility | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy 1.00	Amount 2.00	mm/dd/yyyy 3.00	Amount 4.00	
1.00	Total interim payments paid to provider		478,110		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		478,110		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		478,110		0	7.00

			Contractor Number 1.00	Date (Mo/Day/Yr) 2.00	
8.00	Name of Contractor	0			8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 151319	Period: From 10/01/2011 To 09/30/2012	Worksheet E-1 Part II Date/Time Prepared: 2/20/2013 1:52 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14	641	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	1,446	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	334	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	2,282	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	48,441,522	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	1,859,979	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	54,512	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	54,512	8.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	54,512	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 minus line 30 and line 31)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet E-2

Component CCN: 15Z319 | Date/Time Prepared: 2/20/2013 1:52 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A 1.00	Part B 2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	703,429	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)	221,176	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	698	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	924,605	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	924,605	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	924,605	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	16,501	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	908,104	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
17.00	Reimbursable bad debts (see instructions)	0	0	17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)	908,104	0	19.00
20.00	Interim payments	875,085	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)	33,019	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet E-3 Part V | Date/Time Prepared: 2/20/2013 1:52 pm

Title XVIII | Hospital | Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)		
1.00	Inpatient services	2,831,797	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 thru 3)	2,831,797	4.00
5.00	Primary payer payments	3,023	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,857,092	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	2,857,092	19.00
20.00	Deductibles (exclude professional component)	369,166	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20)	2,487,926	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	2,487,926	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	27,991	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	27,991	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,515,917	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)	2,515,917	30.00
31.00	Interim payments	2,446,943	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus the sum of lines 31, and 32)	68,974	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151319 Component CCN: 155093	Period: From 10/01/2011 To 09/30/2012	Worksheet E-3 Part VI Date/Time Prepared: 2/20/2013 1:52 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	615,628	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	615,628	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	137,518	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Allowable reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)	478,110	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (line 12 minus 13 ± lines 14	478,110	15.00
16.00	Interim payments	478,110	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus the sum of lines 16 and 17)	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, section 115.2	0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet E-3 Part VII Date/Time Prepared: 2/20/2013 1:52 pm

Title XIX

		Hospital Inpatient 1.00	PPS Outpatient 2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		1,397,772	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	1,397,772	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	1,397,772	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	245,841	4,579,314	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	245,841	4,579,314	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	245,841	4,579,314	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	245,841	3,181,542	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	1,397,772	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	1,397,772	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	1,397,772	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	1,397,772	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	1,397,772	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	1,397,772	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus 41)	0	1,397,772	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 151319 | Component CCN: 155093 | Period: From 10/01/2011 To 09/30/2012 | Worksheet E-3 Part VII | Date/Time Prepared: 2/20/2013 1:52 pm

Title XIX

		Skilled Nursing Facility Inpatient	Cost Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet G | Date/Time Prepared: 2/20/2013 1:52 pm

		General Fund 1.00	Specific Purpose Fund 2.00	Endowment Fund 3.00	Plant Fund 4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	3,025,995	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	7,136,755	0	0	0	4.00
5.00	Other receivable	571,114	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,824,928	0	0	0	6.00
7.00	Inventory	681,551	0	0	0	7.00
8.00	Prepaid expenses	162,029	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	7,752,516	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	29,960,120	0	0	0	15.00
16.00	Accumulated depreciation	-18,764,628	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	11,195,492	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	4,561,693	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,561,693	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	23,509,701	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	717,856	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,611,026	0	0	0	38.00
39.00	Payroll taxes payable	521	0	0	0	39.00
40.00	Notes and loans payable (short term)	711,131	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	121,727	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,162,261	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	9,010,063	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	9,010,063	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	12,172,324	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	11,337,377				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	11,337,377	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	23,509,701	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet G-1 | Date/Time Prepared: 2/20/2013 1:52 pm

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
1.00	Fund balances at beginning of period		9,246,391		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,804,109			2.00
3.00	Total (sum of line 1 and line 2)		11,050,500		0	3.00
4.00	Additions (credit adjustments) (specify)	286,877		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		286,877		0	10.00
11.00	Subtotal (line 3 plus line 10)		11,337,377		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		11,337,377		0	19.00

		Endowment Fund		Plant Fund		
		5.00	6.00	7.00	8.00	
1.00	Fund balances at beginning of period		0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)		0		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		0		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/20/2013 1:52 pm

	Cost Center Description	Inpatient 1.00	Outpatient 2.00	Total 3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,323,551		2,323,551	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	1,972,579		1,972,579	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	4,296,130		4,296,130	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	452,352		452,352	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	452,352		452,352	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,748,482		4,748,482	17.00
18.00	Ancillary services	7,214,846	35,458,093	42,672,939	18.00
19.00	Outpatient services	0	340,021	340,021	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		508,131	508,131	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	MOB AND ASC	0	1,183,222	1,183,222	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	11,963,328	37,489,467	49,452,795	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		31,260,827		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	NON OPERATING EXPENSE	2,633,205			37.00
38.00	INDUSTRIAL MEDICINE EXPENSE	3,718,452			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		6,351,657		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		24,909,170		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet G-3 | Date/Time Prepared: 2/20/2013 1:52 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	49,452,795	1.00
2.00	Less contractual allowances and discounts on patients' accounts	22,916,367	2.00
3.00	Net patient revenues (line 1 minus line 2)	26,536,428	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	24,909,170	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,627,258	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	760,078	24.00
24.01	NET INDUSTRIAL MEDICINE	270,247	24.01
24.02	NON OPERATING INCOME	601,604	24.02
25.00	Total other income (sum of lines 6-24)	1,631,929	25.00
26.00	Total (line 5 plus line 25)	3,259,187	26.00
27.00	NET NON OPERATING REVENUE	1,455,078	27.00
27.01		0	27.01
27.02		0	27.02
28.00	Total other expenses (sum of line 27 and subscripts)	1,455,078	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,804,109	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 151319 HHA CCN: 157445 | Period: From 10/01/2011 To 09/30/2012 | Worksheet H | Date/Time Prepared: 2/20/2013 1:52 pm

		Salaries	Employee Benefits	Transportation (see instructions)	Home Health Agency I Contracted/Purchased Services	PPS Other Costs	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures			0		0	1.00
2.00	Capital Related - Movable Equipment			0		0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	65,680	25,258	27,240	0	19,574	5.00
	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	130,260	50,092	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	39,622	15,237	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	699	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	235,562	90,587	27,240	0	20,273	24.00

Column, 6 line 24 should agree with the Worksheet A, column 7, line 101, or subscript as applicable.

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 151319 HHA CCN: 157445 | Period: From 10/01/2011 To 09/30/2012 | Worksheet H | Date/Time Prepared: 2/20/2013 1:52 pm

		Total (sum of cols. 1 thru 5)	Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Home Health Agency I Adjustments	PPS Net Expenses for Allocation (col. 8 + col. 9)	
		6.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0	0	1.00
2.00	Capital Related - Movable Equipment	0	0	0	0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	137,752	-14,020	123,732	0	123,732	5.00
	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	180,352	0	180,352	0	180,352	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	54,859	0	54,859	0	54,859	11.00
12.00	Supplies (see instructions)	699	0	699	0	699	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	373,662	-14,020	359,642	0	359,642	24.00

Column, 6 line 24 should agree with the Worksheet A, column 7, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 151319 | HHA CCN: 157445 | Period: From 10/01/2011 To 09/30/2012 | Worksheet H-1 Part I | Date/Time Prepared: 2/20/2013 1:52 pm

Home Health Agency I | PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	
		0	1.00	2.00	3.00	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures	0	0				1.00
2.00	Capital Related - Movable Equipment	0		0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	123,732	0	0	0	0	5.00
	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	180,352	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	54,859	0	0	0	0	11.00
12.00	Supplies (see instructions)	699	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		13.00
14.00	DME	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	359,642	0	0	0	0	24.00

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 151319 | HHA CCN: 157445 | Period: From 10/01/2011 To 09/30/2012 | Worksheet H-1 Part I | Date/Time Prepared: 2/20/2013 1:52 pm

Home Health Agency I | PPS

		Subtotal (cols. 0-4) 4A.00	Administrative & General 5.00	Total (cols. 4A + 5) 6.00			
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures	0					1.00
2.00	Capital Related - Movable Equipment	0					2.00
3.00	Plant Operation & Maintenance	0					3.00
4.00	Transportation						4.00
5.00	Administrative and General	123,732	123,732				5.00
	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	180,352	94,592	274,944			6.00
7.00	Physical Therapy	0	0	0			7.00
8.00	Occupational Therapy	0	0	0			8.00
9.00	Speech Pathology	0	0	0			9.00
10.00	Medical Social Services	0	0	0			10.00
11.00	Home Health Aide	54,859	28,773	83,632			11.00
12.00	Supplies (see instructions)	699	367	1,066			12.00
13.00	Drugs	0	0	0			13.00
14.00	DME	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0			17.00
18.00	Clinic	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0			19.00
20.00	Day Care Program	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0			21.00
22.00	Homemaker Service	0	0	0			22.00
23.00	All Others (specify)	0	0	0			23.00
24.00	Total (sum of lines 1-23)	359,642		359,642			24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 151319 | Period: From 10/01/2011 | Worksheet H-1 Part II
HHA CCN: 157445 | To 09/30/2012 | Date/Time Prepared: 2/20/2013 1:52 pm

		Capital Related Costs			Home Health Agency I	PPS	
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	
		1.00	2.00	3.00	4.00	5A.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures	0				0	1.00
2.00	Capital Related - Movable Equipment		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-123,732	5.00
	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-123,732	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		26.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 151319 | HHA CCN: 157445 | Period: From 10/01/2011 To 09/30/2012 | Worksheet H-1 Part II Date/Time Prepared: 2/20/2013 1:52 pm

Home Health Agency I | PPS

		Administrative & General (ACCUM. COST) 5.00		
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation (see instructions)			4.00
5.00	Administrative and General	235,910		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	180,352		6.00
7.00	Physical Therapy	0		7.00
8.00	Occupational Therapy	0		8.00
9.00	Speech Pathology	0		9.00
10.00	Medical Social Services	0		10.00
11.00	Home Health Aide	54,859		11.00
12.00	Supplies (see instructions)	699		12.00
13.00	Drugs	0		13.00
14.00	DME	0		14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0		15.00
16.00	Respiratory Therapy	0		16.00
17.00	Private Duty Nursing	0		17.00
18.00	Clinic	0		18.00
19.00	Health Promotion Activities	0		19.00
20.00	Day Care Program	0		20.00
21.00	Home Delivered Meals Program	0		21.00
22.00	Homemaker Service	0		22.00
23.00	All Others (specify)	0		23.00
24.00	Total (sum of lines 1-23)	235,910		24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	123,732		25.00
26.00	Unit Cost Multiplier	0.524488		26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet H-2 Part I
HHA CCN: 157445 | Date/Time Prepared: 2/20/2013 1:52 pm

Home Health Agency I | PPS

	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS NEW BLDG & FIXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
		0	1.00	2.00	4.00	4A	
1.00	Administrative and General	0	5,880	6,589	10,301	22,770	1.00
2.00	Skilled Nursing Care	274,944	0	0	0	274,944	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	83,632	0	0	0	83,632	7.00
8.00	Supplies (see instructions)	1,066	0	0	0	1,066	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	359,642	5,880	6,589	10,301	382,412	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000	21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet H-2 Part I | Date/Time Prepared: 2/20/2013 1:52 pm

HHA CCN: 157445 | Home Health Agency I | PPS

	Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
1.00	Administrative and General	4,732	13,116	0	4,921	0	1.00
2.00	Skilled Nursing Care	57,138	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	17,380	0	0	0	0	7.00
8.00	Supplies (see instructions)	222	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	79,472	13,116	0	4,921	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151319 | HHA CCN: 157445 | Period: From 10/01/2011 To 09/30/2012 | Worksheet H-2 Part I | Date/Time Prepared: 2/20/2013 1:52 pm

	Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Home Health Agency I Subtotal	PPS Intern & Residents Cost & Post Stepdown Adjustments	
		11.00	13.00	16.00	24.00	25.00	
1.00	Administrative and General	0	0	1,342	46,881	0	1.00
2.00	Skilled Nursing Care	0	0	0	332,082	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	101,012	0	7.00
8.00	Supplies (see instructions)	0	0	0	1,288	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	1,342	481,263	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151319 | Period: From 10/01/2011 | Worksheet H-2 Part I
HHA CCN: 157445 | To 09/30/2012 | Date/Time Prepared: 2/20/2013 1:52 pm

Home Health Agency I | PPS

	Cost Center Description	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs			
		26.00	27.00	28.00			
1.00	Administrative and General	46,881					1.00
2.00	Skilled Nursing Care	332,082	35,840	367,922			2.00
3.00	Physical Therapy	0	0	0			3.00
4.00	Occupational Therapy	0	0	0			4.00
5.00	Speech Pathology	0	0	0			5.00
6.00	Medical Social Services	0	0	0			6.00
7.00	Home Health Aide	101,012	10,902	111,914			7.00
8.00	Supplies (see instructions)	1,288	139	1,427			8.00
9.00	Drugs	0	0	0			9.00
10.00	DME	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0			13.00
14.00	Clinic	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0			15.00
16.00	Day Care Program	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0			17.00
18.00	Homemaker Service	0	0	0			18.00
19.00	All Others (specify)	0	0	0			19.00
20.00	Total (sum of lines 1-19) (2)	481,263	46,881	481,263			20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		0.107926				21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 151319 HHA CCN: 157445

Period: From 10/01/2011 To 09/30/2012

Worksheet H-2 Part II Date/Time Prepared: 2/20/2013 1:52 pm

Home Health Agency I

PPS

	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET) 1.00	NEW MVBLE EQUIP (SQUARE FEET) 2.00	EMPLOYEE BENEFITS (GROSS SALARIES) 4.00	Reconciliation 5A	ADMINISTRATIVE & GENERAL (ACCUM. COST) 5.00	
1.00	Administrative and General	505	505	235,562	0	22,770	1.00
2.00	Skilled Nursing Care	0	0	0	0	274,944	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	83,632	7.00
8.00	Supplies (see instructions)	0	0	0	0	1,066	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	505	505	235,562		382,412	20.00
21.00	Total cost to be allocated	5,880	6,589	10,301		79,472	21.00
22.00	Unit cost multiplier	11.643564	13.047525	0.043729		0.207818	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 151319 | HHA CCN: 157445 | Period: From 10/01/2011 To 09/30/2012 | Worksheet H-2 Part II | Date/Time Prepared: 2/20/2013 1:52 pm

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	Home Health Agency I DIETARY (MEALS SERVED)	PPS CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	505	0	505	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	505	0	505	0	0	20.00
21.00	Total cost to be allocated	13,116	0	4,921	0	0	21.00
22.00	Unit cost multiplier	25.972277	0.000000	9.744554	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet H-2 Part II | Date/Time Prepared: 2/20/2013 1:52 pm

HHA CCN: 157445 | Home Health Agency I | PPS

	Cost Center Description	NURSING ADMINISTRATION (NRSE FTE'S)	MEDICAL RECORDS & LIBRARY (TIME SPENT)			
		13.00	16.00			
1.00	Administrative and General	0	1			1.00
2.00	Skilled Nursing Care	0	0			2.00
3.00	Physical Therapy	0	0			3.00
4.00	Occupational Therapy	0	0			4.00
5.00	Speech Pathology	0	0			5.00
6.00	Medical Social Services	0	0			6.00
7.00	Home Health Aide	0	0			7.00
8.00	Supplies (see instructions)	0	0			8.00
9.00	Drugs	0	0			9.00
10.00	DME	0	0			10.00
11.00	Home Dialysis Aide Services	0	0			11.00
12.00	Respiratory Therapy	0	0			12.00
13.00	Private Duty Nursing	0	0			13.00
14.00	Clinic	0	0			14.00
15.00	Health Promotion Activities	0	0			15.00
16.00	Day Care Program	0	0			16.00
17.00	Home Delivered Meals Program	0	0			17.00
18.00	Homemaker Service	0	0			18.00
19.00	All Others (specify)	0	0			19.00
20.00	Total (sum of lines 1-19)	0	1			20.00
21.00	Total cost to be allocated	0	1,342			21.00
22.00	Unit cost multiplier	0.000000	1,342.000000			22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet H-3 Parts I-II
HHA CCN: 157445 | Date/Time Prepared: 2/20/2013 1:52 pm

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	
		0	1.00	2.00	3.00	4.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION						
	Cost Per Visit Computation						
1.00	Skilled Nursing Care	2.00	367,922		367,922	1,928	1.00
2.00	Physical Therapy	3.00	0	0	0	1,179	2.00
3.00	Occupational Therapy	4.00	0	0	0	189	3.00
4.00	Speech Pathology	5.00	0	0	0	25	4.00
5.00	Medical Social Services	6.00	0		0	0	5.00
6.00	Home Health Aide	7.00	111,914		111,914	835	6.00
7.00	Total (sum of lines 1-6)		479,836	0	479,836	4,156	7.00

Program Visits

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles	
		0	1.00	2.00	3.00	4.00	
	Limitation Cost Computation						
8.00	Skilled Nursing Care		21780	756	602		8.00
9.00	Physical Therapy		21780	540	374		9.00
10.00	Occupational Therapy		21780	56	89		10.00
11.00	Speech Pathology		21780	16	12		11.00
12.00	Medical Social Services		21780	0	0		12.00
13.00	Home Health Aide		21780	319	296		13.00
14.00	Total (sum of lines 8-13)			1,687	1,373		14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	
		0	1.00	2.00	3.00	4.00	
	Supplies and Drugs Cost Computations						
15.00	Cost of Medical Supplies	8.00	1,427	0	1,427	3,099	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	16.00

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	
		0	1.00	2.00	3.00	
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS					
1.00	Physical Therapy	66.00	0.312536	0	0	1.00
2.00	Occupational Therapy	67.00	0.257242	0	0	2.00
3.00	Speech Pathology	68.00	0.369031	0	0	3.00
4.00	Cost of Medical Supplies	71.00	0.300880	0	0	4.00
5.00	Cost of Drugs	73.00	0.414180	0	0	5.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151319 | Period: From 10/01/2011 | Worksheet H-3 Parts I-II
HHA CCN: 157445 | To 09/30/2012 | Date/Time Prepared: 2/20/2013 1:52 pm
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	Cost Center Description	Average Cost Per Visit (col. 3 ÷ col. 4)	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance		
		5.00	6.00	7.00	8.00		
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION						
	Cost Per Visit Computation						
1.00	Skilled Nursing Care	190.83	756	602			1.00
2.00	Physical Therapy	0.00	540	374			2.00
3.00	Occupational Therapy	0.00	56	89			3.00
4.00	Speech Pathology	0.00	16	12			4.00
5.00	Medical Social Services	0.00	0	0			5.00
6.00	Home Health Aide	134.03	319	296			6.00
7.00	Total (sum of lines 1-6)		1,687	1,373			7.00
	Cost Center Description	5.00	6.00	7.00	8.00	9.00	
	Limitation Cost Computation						
8.00	Skilled Nursing Care						8.00
9.00	Physical Therapy						9.00
10.00	Occupational Therapy						10.00
11.00	Speech Pathology						11.00
12.00	Medical Social Services						12.00
13.00	Home Health Aide						13.00
14.00	Total (sum of lines 8-13)						14.00

	Cost Center Description	Ratio (col. 3 ÷ col. 4)	Program Covered Charges Part A	Program Covered Charges Part B Not Subject to Deductibles & Coinsurance	Program Covered Charges Part B Subject to Deductibles & Coinsurance		
		5.00	6.00	7.00	8.00		
	Supplies and Drugs Cost Computations						
15.00	Cost of Medical Supplies	0.460471					15.00
16.00	Cost of Drugs	0.000000		0	0		16.00
	Cost Center Description		Transfer to Part I as Indicated				
			4.00				
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy		col. 2, line 2.00				1.00
2.00	Occupational Therapy		col. 2, line 3.00				2.00
3.00	Speech Pathology		col. 2, line 4.00				3.00
4.00	Cost of Medical Supplies		col. 2, line 15.00				4.00
5.00	Cost of Drugs		col. 2, line 16.00				5.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151319 HHA CCN: 157445 | Period: From 10/01/2011 To 09/30/2012 | Worksheet H-3 Parts I-II Date/Time Prepared: 2/20/2013 1:52 pm

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	Cost Center Description	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	Total Program Cost (sum of cols. 9-10)	
		9.00	10.00	11.00	12.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION					
	Cost Per Visit Computation					
1.00	Skilled Nursing Care	144,267	114,880		259,147	1.00
2.00	Physical Therapy	0	0		0	2.00
3.00	Occupational Therapy	0	0		0	3.00
4.00	Speech Pathology	0	0		0	4.00
5.00	Medical Social Services	0	0		0	5.00
6.00	Home Health Aide	42,756	39,673		82,429	6.00
7.00	Total (sum of lines 1-6)	187,023	154,553		341,576	7.00

	Cost Center Description	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance		
		10.00	11.00	12.00		
	Limitation Cost Computation					
8.00	Skilled Nursing Care					8.00
9.00	Physical Therapy					9.00
10.00	Occupational Therapy					10.00
11.00	Speech Pathology					11.00
12.00	Medical Social Services					12.00
13.00	Home Health Aide					13.00
14.00	Total (sum of lines 8-13)					14.00

	Cost Center Description	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance		
		9.00	10.00	11.00		
	Supplies and Drugs Cost Computations					
15.00	Cost of Medical Supplies					15.00
16.00	Cost of Drugs		0	0		16.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 151319 | Period: From 10/01/2011 To 09/30/2012 | Worksheet H-4 Part I-II
HHA CCN: 157445 | Date/Time Prepared: 2/20/2013 1:52 pm

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		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services 1.00	Part B Services 2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	204,351	176,763	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	1,599	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	2,678	3,661	13.00
14.00	Total PPS Reimbursement - PEP Episodes	4,781	3,983	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	924	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	211,810	186,930	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	211,810	186,930	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	211,810	186,930	26.00
27.00	Reimbursable bad debts (from your records)	0	0	27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	211,810	186,930	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
31.00	Subtotal (line 29 plus/minus line 30)	211,810	186,930	31.00
32.00	Interim payments (see instructions)	211,810	186,929	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 32 and 33)	0	1	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 151319 HHA CCN: 157445 | Period: From 10/01/2011 To 09/30/2012 | Worksheet H-5 | Date/Time Prepared: 2/20/2013 1:52 pm

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		Inpatient Part A		Part B		
		mm/dd/yyyy 1.00	Amount 2.00	mm/dd/yyyy 3.00	Amount 4.00	
1.00	Total interim payments paid to provider		211,810		186,929	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		211,810		186,929	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		1	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		211,810		186,930	7.00

		Contractor Number 1.00	Date (Mo/Day/Yr) 2.00	
8.00	Name of Contractor	0		8.00